ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

RECEIVED
OCT 26 2018
HEALTH FACILITIES & SERVICES REVIEW BOARD

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: Quincy Medical Group Surgery Center		
Street Address: 3347 Broadway		
City and Zip Code: Quincy, Illinois 62301		
County: Adams	Health Service Area: HSA 3	Health Planning Area: E-05

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name: Quincy Physicians & Surgeons Clinic, S.C., d/b/a Quincy Medical Group
Street Address: 1025 Maine Street
City and Zip Code: Quincy, Illinois 62301
Name of Registered Agent: Dan H. Evans
Registered Agent Street Address: 1025 Maine Street
Registered Agent City and Zip Code: Quincy, Illinois 62301
Name of Chief Executive Officer: Carol Brockmiller
CEO Street Address: 1025 Maine Street
CEO City and Zip Code: Quincy, Illinois 62301
CEO Telephone Number: (217) 222-6550

Type of Ownership of Applicants

- ☐ Non-profit Corporation
- ☒ For-profit Corporation
- ☐ Limited Liability Company
- ☐ Partnership
- ☐ Governmental
- ☐ Sole Proprietorship
- ☐ Other

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
- Partnerships must provide the name of the state in which they are organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT 1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact [Person to receive ALL correspondence or inquiries]

Name: Carol Brockmiller
Title: CEO
Company Name: Quincy Physicians & Surgeons Clinic, S.C., d/b/a Quincy Medical Group
Address: 1025 Maine Street, Quincy, Illinois 62301
Telephone Number: (217) 222-6550
E-mail Address: cbrockmiller@quincymedgroup.com
Fax Number: (217) 228-6891

Additional Contact [Person who is also authorized to discuss the application for permit]

Name: Tracey L. Klein
Title: Attorney
Company Name: Polsinelli PC
Address: 150 N. Riverside Plaza, Ste. 3000, Chicago, Illinois 60606
Telephone Number: 312-873-3613
E-mail Address: tklein@polsinelli.com
Fax Number: 312-819-1910

Additional Contact [Person who is also authorized to discuss the application for permit]

Name: Ralph Weber
Title: President
Company Name: Weber Alliance
Address: 920 Hoffman Lane, Riverwoods, Illinois 60015
Telephone Number: 847-791-0830
E-mail Address:rmweber90@gmail.com
Fax Number: N/A

Post Permit Contact

[Person to receive all correspondence subsequent to permit issuance-**THIS PERSON MUST BE EMPLOYED BY THE LICENSED HEALTH CARE FACILITY AS DEFINED AT 20 ILCS 3960]**

Name: Patty Williamson
Title: Chief Financial Officer
Company Name: Quincy Medical Group
Address: 1025 Maine Street, Quincy, Illinois 62301
Telephone Number: (217) 222-6550
E-mail Address: pwilliamson@quincymedgroup.com
Fax Number: (217) 228-6891

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Quincy-Cullinan, LLC
Address of Site Owner: 420 N. Main Street, East Peoria, Illinois
Street Address or Legal Description of the Site: 3347 Broadway, Quincy, Illinois 62301 **Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease.**
APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

[Provide this information for each applicable facility and insert after this page.]

Exact Legal Name: Quincy Physicians & Surgeons Clinic, S.C., d/b/a Quincy Medical Group

Address: 1025 Maine Street, Quincy, Illinois 62301

☐	Non-profit Corporation	☐	Partnership		
☒	For-profit Corporation *	☐	Governmental		
☐	Limited Liability Company	☐	Sole Proprietorship	☐	Other

- Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.
- **Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.**

*At the time of filing, UnityPoint Health, a non-profit health system, holds approximately 40% of the applicant's common stock.

APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Organizational Relationships

Provide (for each applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.
APPEND DOCUMENTATION AS ATTACHMENT 4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Flood Plain Requirements

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2006-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements, please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at **www.FEMA.gov** or **www.illinoisfloodmaps.org**. **This map must be in a readable format.** In addition, please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2006-5 **(http://www.hfsrb.illinois.gov)**.

APPEND DOCUMENTATION AS ATTACHMENT 5, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.

APPEND DOCUMENTATION AS ATTACHMENT 6, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

DESCRIPTION OF PROJECT

1. Project Classification

[Check those applicable - refer to Part 1110.20 and Part 1120.20(b)]

Part 1110 Classification:

☒ Substantive

☐ Non-substantive

2. Narrative Description

In the space below, provide a brief narrative description of the project. Explain **WHAT** is to be done in **State Board defined terms**, **NOT WHY** it is being done. If the project site does NOT have a street address, include a legal description of the site. Include the rationale regarding the project's classification as substantive or non-substantive.

The applicant, Quincy Physicians & Surgeons Clinic, S.C., d/b/a Quincy Medical Group, proposes to establish a multi-specialty ambulatory surgical treatment center ("ASTC") and cardiac catheterization service. The ASTC will contain five operating rooms and three procedure rooms with one of the five ORs dedicated to cardiac catheterization. There is no traditional cardiac cath lab in the project. The project also includes a CT scanner.

The project will be located at 3347 Broadway in Quincy, Illinois in an existing vacant building within a shopping center. The 26,850 sq ft construction project includes 19,385 sq ft of clinical space and 7,465 sq ft of non-clinical space.

The total capital cost of the project is $19,519,058.

The completion date of the project is March 1, 2021.

The project is classified as substantive because it proposes the establishment of services.

Project Costs and Sources of Funds

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must be equal.

Project Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Preplanning Costs			
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts			
Contingencies			
Architectural/Engineering Fees			
Consulting and Other Fees			
Movable or Other Equipment (not in construction contracts)			
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS			
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities			
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS			
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Related Project Costs

Provide the following information, as applicable, with respect to any land related to the project that will be or has been acquired during the last two calendar years:

Land acquisition is related to project ☐ Yes ☒ No
Purchase Price: $_____
Fair Market Value: $_____

The project involves the establishment of a new facility or a new category of service
☒ Yes ☐ No

If yes, provide the dollar amount of all **non-capitalized** operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.

Estimated start-up costs and operating deficit cost is $ 13,113,821

Project Status and Completion Schedules

For facilities in which prior permits have been issued please provide the permit numbers.

Indicate the stage of the project's architectural drawings:

☐ None or not applicable ☐ Preliminary
☒ Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): March 1, 2021

Indicate the following with respect to project expenditures or to financial commitments (refer to Part 1130.140):

☐ Purchase orders, leases or contracts pertaining to the project have been executed.
☐ Financial commitment is contingent upon permit issuance. Provide a copy of the contingent "certification of financial commitment" document, highlighting any language related to CON Contingencies
☒ Financial Commitment will occur after permit issuance.

APPEND DOCUMENTATION AS ATTACHMENT 8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

State Agency Submittals [Section 1130.620(c)]

Are the following submittals up to date as applicable:
☒ Cancer Registry *
☐ APORS - **Not applicable to Applicant**
☐ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted – **Not applicable to Applicant**
☐ All reports regarding outstanding permits – **Not applicable to Applicant**
Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

*The applicant maintains a cancer registry. The cancer registry database is currently closed due to restructuring, and, as a result, the applicant is unable to enter 2018 updated data at this time. The applicant updated the registry with 2017 data until the registry closed. The applicant will update the database with 2018 information promptly once the database is accessible for updates.

Cost Space Requirements

Provide in the following format, the **Departmental Gross Square Feet (DGSF)** or the **Building Gross Square Feet (BGSF)** and cost. The type of gross square footage either **DGSF** or **BGSF** must be identified. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the department's or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	**Cost**	**Existing**	**Proposed**	**New Const.**	**Modernized**	**As Is**	**Vacated Space**
REVIEWABLE							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
NON REVIEWABLE							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
TOTAL							

APPEND DOCUMENTATION AS ATTACHMENT 9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Facility Bed Capacity and Utilization – NOT APPLICABLE TO APPLICANT

Complete the following chart, as applicable. Complete a separate chart for each facility that is a part of the project and insert the chart after this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which data is available. Include observation days in the patient day totals for each bed service.** Any bed capacity discrepancy from the Inventory will result in the application being deemed **incomplete**.

FACILITY NAME:		**CITY:**			
REPORTING PERIOD DATES:		**From:**	**to:**		
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical					
Obstetrics					
Pediatrics					
Intensive Care					
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify)					
TOTALS:					

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:

- in the case of a corporation, any two of its officers or members of its Board of Directors;
- in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of Quincy Physicians & Surgeons Clinic, S.C., d/b/a Quincy Medical Group* **in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the fee required for this application is sent herewith or will be paid upon request.**

Carol Brockmiller
SIGNATURE

Carol Brockmiller
PRINTED NAME

CEO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 22ND day of October, 2018

Joann Eversden
Signature of Notary

Seal

"OFFICIAL SEAL"
JOANN EVERSDEN
Notary Public, State of Illinois
My Commission Expires 09/27/21

SIGNATURE

Todd Petty, MD
PRINTED NAME

Board of Directors, Chairman
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 22ND day of October, 2018

Joann Eversden
Signature of Notary

Seal

"OFFICIAL SEAL"
JOANN EVERSDEN
Notary Public, State of Illinois
My Commission Expires 09/27/21

*Insert the EXACT legal name of the applicant

SECTION II. DISCONTINUATION – NOT APPLICABLE

This Section is applicable to the discontinuation of a health care facility maintained by a State agency.
NOTE: If the project is solely for discontinuation and if there is no project cost, the remaining Sections of the application are not applicable.

Criterion 1110.290 – Discontinuation (State-Owned Facilities and All Relocations)

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

1. Identify the categories of service and the number of beds, if any that is to be discontinued.
2. Identify all of the other clinical services that are to be discontinued.
3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.
4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued and the length of time the records will be maintained.
6. For applications involving the discontinuation of an entire facility, certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 90 days following the date of discontinuation.

REASONS FOR DISCONTINUATION

The applicant shall state the reasons for the discontinuation and provide data that verifies the need for the proposed action. See criterion 1110.290(b) for examples.

IMPACT ON ACCESS

1. Document whether or not the discontinuation of each service or of the entire facility will have an adverse effect upon access to care for residents of the facility's market area.
2. Document that a written request for an impact statement was received by all existing or approved health care facilities (that provide the same services as those being discontinued) located within 45 minutes travel time of the applicant facility.

APPEND DOCUMENTATION AS ATTACHMENT 10, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION III. BACKGROUND, PURPOSE OF THE PROJECT, AND ALTERNATIVES - INFORMATION REQUIREMENTS

This Section is applicable to all projects except those that are solely for discontinuation with no project costs.

1110.110(a) – Background of the Applicant

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.

2. A listing of all health care facilities currently owned and/or operated in Illinois, by any corporate officers or directors, LLC members, partners, or owners of at least 5% of the proposed health care facility. None

3. For the following questions, please provide information for each applicant, including corporate officers or directors, LLC members, partners and owners of at least 5% of the proposed facility. A health care facility is considered owned or operated by every person or entity that owns, directly or indirectly, an ownership interest.

    a. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant, directly or indirectly, during the three years prior to the filing of the application.

    b. A certified listing of each applicant, identifying those individuals that have been cited, arrested, taken into custody, charged with, indicted, convicted or tried for, or pled guilty to the commission of any felony or misdemeanor or violation of the law, except for minor parking violations; or the subject of any juvenile delinquency or youthful offender proceeding. Unless expunged, provide details about the conviction and submit any police or court records regarding any matters disclosed.

    c. A certified and detailed listing of each applicant or person charged with fraudulent conduct or any act involving moral turpitude.

    d. A certified listing of each applicant with one or more unsatisfied judgements against him or her.

    e. A certified and detailed listing of each applicant who is in default in the performance or discharge of any duty or obligation imposed by a judgment, decree, order or directive of any court or governmental agency.

4. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**

5. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest that the information was previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

APPEND DOCUMENTATION AS ATTACHMENT 11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 11.

Criterion 1110.110(b) & (d)

PURPOSE OF PROJECT

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.
2. Define the planning area or market area, or other relevant area, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed as applicable and appropriate for the project.
4. Cite the sources of the documentation.
5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.
6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals **as appropriate**.

For projects involving modernization, describe the conditions being upgraded, if any. For facility projects, include statements of the age and condition of the project site, as well as regulatory citations, if any. For equipment being replaced, include repair and maintenance records.

NOTE: Information regarding the "Purpose of the Project" will be included in the State Board Staff Report.

APPEND DOCUMENTATION AS ATTACHMENT 12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-6) MUST BE IDENTIFIED IN ATTACHMENT 12.

ALTERNATIVES

1) Identify **ALL** of the alternatives to the proposed project:

Alternative options **must** include:

A) Proposing a project of greater or lesser scope and cost;

B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;

C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and

D) Provide the reasons why the chosen alternative was selected.

2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality and financial benefits in both the short-term (within one to three years after project completion) and long-term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED, THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**

3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

APPEND DOCUMENTATION AS ATTACHMENT 13, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IV. PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE

Criterion 1110.120 - Project Scope, Utilization, and Unfinished/Shell Space

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive. **This must be a narrative and it shall include the basis used for determining the space and the methodology applied.**

2. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following:

    a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies and certified by the facility's Medical Director.

    b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that delineates the constraints or impediments.

    c. The project involves the conversion of existing space that results in excess square footage.

    d. Additional space is mandated by governmental or certification agency requirements that were not in existence when Appendix B standards were adopted.

Provide a narrative for any discrepancies from the State Standard. A table must be provided in the following format with Attachment 14.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?

APPEND DOCUMENTATION AS ATTACHMENT 14, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

PROJECT SERVICES UTILIZATION:

This criterion is applicable only to projects or portions of projects that involve services, functions or equipment for which HFSRB has established utilization standards or occupancy targets in 77 Ill. Adm. Code 1100.

Document that in the second year of operation, the annual utilization of the service or equipment shall meet or exceed the utilization standards specified in 1110.Appendix B. **A narrative of the rationale that supports the projections must be provided.**

A table must be provided in the following format with Attachment 15.

UTILIZATION					
	DEPT./ SERVICE	HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.	PROJECTED UTILIZATION	STATE STANDARD	MEET STANDARD?
YEAR 1					
YEAR 2					

APPEND DOCUMENTATION AS ATTACHMENT 15, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

UNFINISHED OR SHELL SPACE: NOT APPLICABLE

Provide the following information:

1. Total gross square footage (GSF) of the proposed shell space.
2. The anticipated use of the shell space, specifying the proposed GSF to be allocated to each department, area or function.
3. Evidence that the shell space is being constructed due to:
   a. Requirements of governmental or certification agencies; or
   b. Experienced increases in the historical occupancy or utilization of those areas proposed to occupy the shell space.
4. Provide:
   a. Historical utilization for the area for the latest five-year period for which data is available; and
   b. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT 16, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

ASSURANCES: NOT APPLICABLE

Submit the following:

1. Verification that the applicant will submit to HFSRB a CON application to develop and utilize the shell space, regardless of the capital thresholds in effect at the time or the categories of service involved.
2. The estimated date by which the subsequent CON application (to develop and utilize the subject shell space) will be submitted; and
3. The anticipated date when the shell space will be completed and placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT 17, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION V. SERVICE SPECIFIC REVIEW CRITERIA

This Section is applicable to all projects proposing the establishment, expansion or modernization of categories of service that are subject to CON review, as provided in the Illinois Health Facilities Planning Act [20 ILCS 3960]. It is comprised of information requirements for each category of service, as well as charts for each service, indicating the review criteria that must be addressed for each action (establishment, expansion, and modernization). After identifying the applicable review criteria for each category of service involved, read the criteria and provide the required information APPLICABLE TO THE CRITERIA THAT MUST BE ADDRESSED:

E. Criterion 1110.225 - Cardiac Catheterization

1. Applicants proposing to establish, expand and/or modernize the Cardiac Catheterization category of service must submit the following information.

2. Indicate bed capacity changes by Service: Indicate # of beds changed by action(s):

Category of Service	# Existing Beds	# Proposed Beds
☒ Cardiac Catheterization	0 Rooms	1 Room

3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

1. Criterion 1110.225(a), Peer Review

Read the criterion and submit a detailed explanation of your peer review program.

2. Criterion 1110. 225(b), Establishment or Expansion of Cardiac Catheterization Service

Read the criterion and, if applicable, submit the following information:

a. A map (on 8 1/2" x 11" paper) showing the location of the other hospitals providing cardiac catheterization services within the planning area.

b. The number of cardiac catheterizations performed for the last 12 months at each of the hospitals shown on the map.

c. Provide the number of patients transferred directly from the applicant's hospital to another facility for cardiac catheterization services in each of the last three years.

3. Criterion 1110.225(c), Unnecessary Duplication of Services

Read the criterion and, if applicable, submit the following information.

a. Copies of the letter sent to all facilities within the planning area that currently provide cardiac catheterization. This letter must contain a description of the proposed project and a request that the other facility quantify the impact of the proposal on its program.

b. Copies of the responses received from the facilities to which the letter was sent.

4. Criterion 1110.225(d), Modernization of Existing Cardiac Catheterization Laboratories

Read the criterion and, if applicable, submit the number of cardiac catheterization procedures performed for the latest 12 months.

5. Criterion 1110.225(e), Support Services

Read the criterion and indicate on a service-by-service basis which of the listed services are available on a 24-hour basis and explain how any services not available on a 24-hour basis will be available when needed.

6. Criterion 1110.225(f), Laboratory Location

Read the criterion and, if applicable, submit line drawings showing the location of the proposed laboratories. If the laboratories are not in close proximity, explain why.

7. **Criterion 1110.225(g), Staffing**

   Read the criterion and submit a list of names and qualifications of those who will fill the positions detailed in this criterion. Also, provide staffing schedules to show the coverage required by this criterion.

8. **Criterion 1110.225(h), Continuity of Care**

   Read the criterion and submit a copy of the fully executed written referral agreement(s).

9. **Criterion 1110.225(i), Multi-institutional Variance**

   Read the criterion and, if applicable, submit the following information:

   a. A copy of a fully executed affiliation agreement between the two facilities involved.

   b. Names and positions of the shared staff at the two facilities.

   c. The volume of open heart surgeries performed for the latest 12-month period at the existing operating program.

   d. A cost comparison between the proposed project and expansion at the existing operating program.

   e. The number of cardiac catheterization procedures performed in the last 12 months at the operating program.

   f. The number of catheterization laboratories at the operating program.

   g. The projected cardiac catheterization volume at the proposed facility annually for the next 2 years.

   h. The basis for the above projection.

APPEND DOCUMENTATION AS ATTACHMENT 22 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

G. Non-Hospital Based Ambulatory Surgery

Applicants proposing to establish, expand and/or modernize the Non-Hospital Based Ambulatory Surgery category of service must submit the following information.

ASTC Service
☒ Cardiovascular
☒ Colon and Rectal Surgery
☐ Dermatology
☐ General Dentistry
☒ General Surgery
☒ Gastroenterology
☒ Neurological Surgery
☐ Nuclear Medicine
☒ Obstetrics/Gynecology
☒ Ophthalmology
☒ Oral/Maxillofacial Surgery
☒ Orthopedic Surgery
☒ Otolaryngology
☐ Pain Management
☐ Physical Medicine and Rehabilitation
☒ Plastic Surgery
☒ Podiatric Surgery
☐ Radiology
☐ Thoracic Surgery
☒ Urology
☒ Other - Pulmonology, Cardiac Catheterization

3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

APPLICABLE REVIEW CRITERIA	Establish New ASTC or Service	Expand Existing Service
1110.235(c)(2)(B) – Service to GSA Residents	X	X
1110.235(c)(3) – Service Demand – Establishment of an ASTC or Additional ASTC Service	X	
1110.235(c)(4) – Service Demand – Expansion of Existing ASTC Service		X
1110.235(c)(5) – Treatment Room Need Assessment	X	X
1110.235(c)(6) – Service Accessibility	X	
1110.235(c)(7)(A) – Unnecessary Duplication/Maldistribution	X	
1110.235(c)(7)(B) – Maldistribution	X	
1110.235(c)(7)(C) – Impact to Area Providers	X	

1110.235(c)(8) – Staffing	X	X
1110.235(c)(9) – Charge Commitment	X	X
1110.235(c)(10) – Assurances	X	X

APPEND DOCUMENTATION AS ATTACHMENT 24, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

M. Criterion 1110.270 - Clinical Service Areas Other than Categories of Service

1. Applicants proposing to establish, expand and/or modernize Clinical Service Areas Other than categories of service must submit the following information:

2. Indicate changes by Service: Indicate # of key room changes by action(s):

Service	# Existing Key Rooms	# Proposed Key Rooms
☒ **CT Scanner**	**0**	**1**
☐		
☐		

3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

Project Type	Required Review Criteria
New Services or Facility or Equipment	(b) – Need Determination – Establishment
Service Modernization	(c)(1) – Deteriorated Facilities
	AND/OR
	(c)(2) – Necessary Expansion
	PLUS
	(c)(3)(A) – Utilization – Major Medical Equipment
	OR
	(c)(3)(B) – Utilization – Service or Facility
APPEND DOCUMENTATION AS ATTACHMENT 30, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

The following Sections DO NOT need to be addressed by the applicants or co-applicants responsible for funding or guaranteeing the funding of the project if the applicant has a bond rating of A- or better from Fitch's or Standard and Poor's rating agencies, or A3 or better from Moody's (the rating shall be affirmed within the latest 18-month period prior to the submittal of the application):

- **Section 1120.120 Availability of Funds – Review Criteria**
- **Section 1120.130 Financial Viability – Review Criteria**
- **Section 1120.140 Economic Feasibility – Review Criteria, subsection (a)**

VI. 1120.120 - AVAILABILITY OF FUNDS

The applicant shall document that financial resources shall be available and be equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources from the following sources, as applicable **[Indicate the dollar amount to be provided from the following sources]:**

$1,767,096	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: 1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and 2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
_____	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
_____	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
$4,928,593	d)	Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated; 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate; 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.; 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment; 5) For any option to lease, a copy of the option, including all terms and conditions.

_____	e) Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent;
_____	f) Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
$12,823,368	g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project. **(FMV Lease)**
$19,519,058	**TOTAL FUNDS AVAILABLE**

APPEND DOCUMENTATION AS ATTACHMENT 33, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VII. 1120.130 - FINANCIAL VIABILITY

All the applicants and co-applicants shall be identified, specifying their roles in the project funding or guaranteeing the funding (sole responsibility or shared) and percentage of participation in that funding.

Financial Viability Waiver – NOT APPLICABLE

The applicant is not required to submit financial viability ratios if:

1. "A" Bond rating or better
2. All of the projects capital expenditures are completely funded through internal sources
3. The applicant's current debt financing or projected debt financing is insured or anticipated to be insured by MBIA (Municipal Bond Insurance Association Inc.) or equivalent
4. The applicant provides a third party surety bond or performance bond letter of credit from an A rated guarantor.

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT 34, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

The applicant or co-applicant that is responsible for funding or guaranteeing funding of the project shall provide viability ratios for the latest three years for which **audited financial statements are available and for the first full fiscal year at target utilization, but no more than two years following project completion.** When the applicant's facility does not have facility specific financial statements and the facility is a member of a health care system that has combined or consolidated financial statements, the system's viability ratios shall be provided. If the health care system includes one or more hospitals, the system's viability ratios shall be evaluated for conformance with the applicable hospital standards.

	Historical 3 Years			Projected
Enter Historical and/or Projected Years:				
Current Ratio				
Net Margin Percentage				
Percent Debt to Total Capitalization				
Projected Debt Service Coverage				
Days Cash on Hand				
Cushion Ratio				

Provide the methodology and worksheets utilized in determining the ratios detailing the calculation and applicable line item amounts from the financial statements. Complete a separate table for each co-applicant and provide worksheets for each.

Variance

Applicants not in compliance with any of the viability ratios shall document that another organization, public or private, shall assume the legal responsibility to meet the debt obligations should the applicant default.

APPEND DOCUMENTATION AS ATTACHMENT 35, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VIII.1120.140 - ECONOMIC FEASIBILITY

This section is applicable to all projects subject to Part 1120.

A. Reasonableness of Financing Arrangements

The applicant shall document the reasonableness of financing arrangements by submitting a notarized statement signed by an authorized representative that attests to one of the following:

1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or

2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:

   A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or

   B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Conditions of Debt Financing

This criterion is applicable only to projects that involve debt financing. The applicant shall document that the conditions of debt financing are reasonable by submitting a notarized statement signed by an authorized representative that attests to the following, as applicable:

1) That the selected form of debt financing for the project will be at the lowest net cost available;

2) That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;

3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

1. Identify each department or area impacted by the proposed project and provide a cost and square footage allocation for new construction and/or modernization using the following format (insert after this page).

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE

Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot		Gross Sq. Ft.		Gross Sq. Ft.		Const. $ (A x C)	Mod. $ (B x E)	
	New	Mod.	New	Circ.*	Mod.	Circ.*			
Contingency									
TOTALS									

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service.

E. Total Effect of the Project on Capital Costs

The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.

APPEND DOCUMENTATION AS ATTACHMENT 36, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IX. SAFETY NET IMPACT STATEMENT

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL SUBSTANTIVE PROJECTS AND PROJECTS TO DISCONTINUE STATE-OWNED HEALTH CARE FACILITIES [20 ILCS 3960/5.4]:

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.

2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.

3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all of the following:

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.

2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.

3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

A table in the following format must be provided as part of Attachment 38.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**Year**	**Year**	**Year**
Inpatient			
Outpatient			
Total			
Charity (cost In dollars)			
Inpatient			
Outpatient			
Total			
MEDICAID			
Medicaid (# of patients)	**Year**	**Year**	**Year**
Inpatient			
Outpatient			
Total			
Medicaid (revenue)			
Inpatient			

Outpatient			
Total			

APPEND DOCUMENTATION AS ATTACHMENT 37, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION X. CHARITY CARE INFORMATION

Charity Care information MUST be furnished for ALL projects [1120.20(c)].

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.

2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.

3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer (20 ILCS 3960/3). Charity Care must be provided at cost.

A table in the following format must be provided for all facilities as part of Attachment 39.

CHARITY CARE			
	Year	Year	Year
Net Patient Revenue			
Amount of Charity Care (charges)			
Cost of Charity Care			

APPEND DOCUMENTATION AS ATTACHMENT 38, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

After paginating the entire completed application indicate, in the chart below, the page numbers for the included attachments:

INDEX OF ATTACHMENTS

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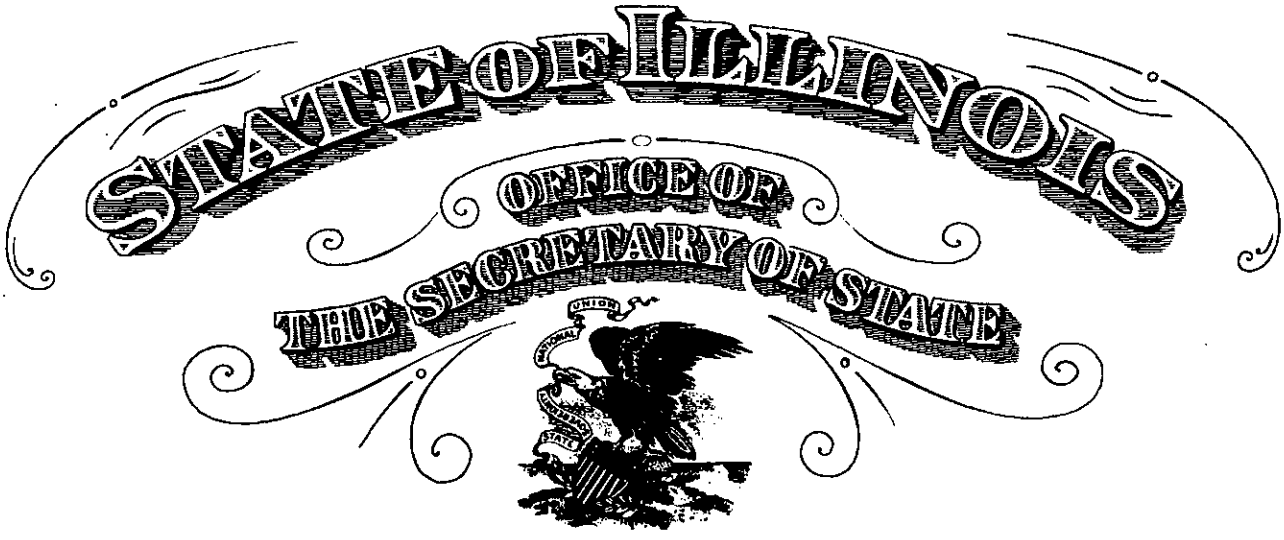
Attachment 1 – Type of Ownership of Applicant

The applicant is a for-profit corporation. Attached is an Illinois Certificate of Good Standing for Quincy Physicians & Surgeons Clinic, S.C., d/b/a Quincy Medical Group.

Attachment 1

File Number 5448-637-5



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

QUINCY PHYSICIANS & SURGEONS CLINIC, S.C., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON DECEMBER 19, 1986, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE RELATING TO THE PAYMENT OF FRANCHISE TAXES, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 9TH *day of* OCTOBER *A.D.* 2018 .

Authentication #: 1828201090 verifiable until 10/09/2019
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

Attachment 1

Attachment 2 – Site Ownership

Attachment 2 contains the Limited Warranty Deed showing Quincy-Cullinan, LLC as the owner of the property. Exhibit A of the Limited Warranty Deed provides the legal description of the property. 3347 Broadway, the project site, is part of the property. Attachment 2 also includes a letter of intent by QMG to lease the property at 3347 Broadway. The letter refers to the use of the building for "medical services." These include the ambulatory surgery treatment center, inclusive of the cardiac catheterization service, and a CT scanning service which are the subject of the Certificate of Need permit application. Also included as "medical services," but not subject to CON and not part of the permit application, are a radiation oncology service and infusion therapy (chemotherapy), with supporting oncology physician offices.

Attachment 2

Adams County Clerk/Recorder
Book: 706 Page: 3349
Receipt #: 200200382
Pages Recorded: 4
Recording Fee: $25.00
Total Revenue Stamp: $36,000.00
Adams County Revenue Stamp $12,000.00
Illinois St Revenue Stamp $24,000.00
Rental Housing Support Program State Surcharge Pd 4/7/2006 $10.00
Date Recorded: 4/7/2006 10:37:11 AM

Adams County Abstract

LIMITED WARRANTY DEED

Quincy Mall, Inc., an Ohio corporation, hereinafter "Grantor," for valuable consideration given by Quincy-Cullinan, LLC, an Illinois limited liability company, hereinafter "Grantee", whose tax mailing address is One Technology Plaza, 211 Fulton Street, Suite 700, Peoria, Illinois 61602 does hereby grant with limited warranty covenants to Grantee, the following described real property located in the County of Adams, State of Illinois:

(See Legal Description attached hereto as Exhibit A and made a part hereof)

Subject, however, to all taxes and assessments not yet due and payable, and to all encumbrances, easements, conditions and restrictions of record, and to all leases, recorded and unrecorded.

Prior Instrument Reference: Deed Records 388, Page 308, Adams County, Illinois Recorder's Office

Parcel Numbers: 23-7-0661-000-00 Tract I
23-7-0661-006-00 Tract II

Property Address: 3300 Broadway Street, Quincy, Illinois 61301

In Witness Whereof, Grantor has executed this deed as of 4th day of April, 2006.

QUINCY MALL, INC.
an Ohio corporation

JFW

By: _____
Name: **Frank S. Benson III**
Its: **President**

I:\Julia White\Quincy Mall\LIMITED WARRANTY DEED-3-29-06.doc

Attachment 2

STATE OF OHIO)
) SS
COUNTY OF FRANKLIN)

The foregoing instrument was acknowledged before me as of 4th day of April, 2006 by Frank S. Benson III, President of Quincy Mall, Inc., an Ohio corporation, on behalf of such corporation.

Julia Falenski White
Notary Public

NOTARY PUBLIC STATE OF OHIO

JULIA FALENSKI WHITE
ATTORNEY AT LAW
Notary Public, State of Ohio
My Commission Has No Expiration Date
Section 147.03 R.C.

This instrument prepared by:
Julia F. White, Esq.
191 W. Nationwide Blvd., Suite 200
Columbus, Ohio 43215
(614) 228-5331

EXHIBIT A

Tract I:

A part of the South Half of the Southeast Quarter of Section Thirty-one (31) in Township One (1) South of the Base Line and in Range Eight (8) West of the Fourth Principal Meridian, Adams county, Illinois, being more particularly bounded and described as follows, to wit:

Commencing at a stone at the Southeast corner of said Southeast Quarter, thence North 89° 46' West along the South line of said Southeast Quarter Seven Hundred Fifty and Fifty-two Hundredths (750.52) feet, thence North 00° 02' East Thirty-seven and Three Hundredths (37.03) feet to the True Point of Beginning, thence from said True Point of Beginning North 89° 55' West along the North Right-of-Way line of Illinois State Route Number 104 a distance of Five Hundred Fifteen and Three Hundredths (515.03) feet, thence North 00° 02' East along said Right-of-Way line Fifteen (15) feet, thence North 89° 55' West along said Right-of-Way line One Hundred Fifteen (115) feet, thence South 00° 02' West along said Right-of-Way line Fifteen (15) feet, thence North 89° 55' West along said Right-of-Way line Two Hundred Eighty-five and Eighty-nine Hundredths (285.89) feet, thence South 00° 02' West along said Right-of-Way line Ten (10) feet, thence North 89° 55' West along said Right-of-Way line Two Hundred Forty-six and Ninety-three Hundredths (246.93) feet, thence South 00° 02' West along said Right-of-Way line Fifteen (15) feet, thence North 89° 55' West along said Right-of-Way line Two and Twenty-seven Hundredths (2.27) feet, thence North 00° 02' East One Hundred Sixty (160) feet, thence North 89° 55' West Two Hundred Eighteen and Thirty-five Hundredths (218.35) feet, thence South 00° 02' West One Hundred Sixty (160) feet to a point on the North Right-of-way line of said Illinois State Route Number 104, thence North 89° 55' West along said Right-of-Way line Thirty-five (35) feet to the Southeast corner of the Second Farrington Properties, Inc. tract, thence North 00° 02' East along the East line of said Second Farrington Properties, Inc. tract Six Hundred Forty (640) feet, thence North 89° 50' West along the North line of said Second Farrington Properties, Inc. tract Four Hundred Sixty (460) feet to a point on the East line of North 30th Street, thence North 00° 04' West along the East line of said 30th Street Fifty-two and Seventy-nine Hundredths (52.79) feet, thence North 89° 56' East Four Hundred Twenty (420) feet, thence North 00° 04' West Three Hundred Sixteen (316) feet to a point on the centerline of the old Northern Cross Railroad Right-of-Way, said point also being the Southwest corner of Brentwood Subdivision, a Subdivision in the City of Quincy, Illinois, thence North 78° 34' East along said centerline One Thousand Five Hundred Sixty-eight and Twenty Hundredths (1568.20) feet to the intersection with the North line of the South Half of said Southeast Quarter, thence South 89° 34' East along the North line of the South Half of said Southeast Quarter Two Hundred Eighty-seven and Ninety-one Hundredths (287.91) feet, thence South 00° 02' 18" East Fifteen and Fifty Hundredths (15.50) feet, thence South 89° 53' 42' East Seventeen and Nineteen Hundredths (17.19) feet, thence South 00° 06' 18" West One Hundred Forty-five (145) feet, thence South 89° 53' 42" East One Hundred Ten (110) feet, thence North 00° 06' 18' East One Hundred Forty-five (145) feet, thence South 89° 53' 42" East Two Hundred Fifteen (215) feet to a point on the West Right of Way line of North 36th Street, thence South 00° 05' East along the West Right of Way line of said 36th Street Three Hundred Seventy-two and Ninety-six Hundredths (372.96) feet to the Northeast corner of the United States Army Reserve Tract, thence North 89° 55' West along the North line of said United States Army Reserve Tract Four Hundred Fifty-four and Ninety-nine Hundredths (454.99) feet, thence South 00° 03' East along the West line of said United States Army Reserve Tract Two Hundred Fifty-seven and Seventy-seven Hundredths (257.77) feet to the Northeast corner of Sears, Roebuck and Company Tract, thence North 89° 55' West along the North line of said Sears, Roebuck and Company Tract One Hundred Sixty-nine and Thirty-five Hundredths (169.35) feet, thence South 58° 02' 22" West along said North line Fifty-seven and Sixty-four Hundredths (57.64) feet, thence North 89° 55' West along said North line Twenty-three and Eighty-nine Hundredths (23.89) feet, thence South 00° 03' East along said North line Twenty-six and Eighty-nine Hundredths (26.89) feet, thence North 89° 55' West Twelve and Eighty-three Hundredths (12.83) feet, thence South 00° 03' East along the West line of said Sears, Roebuck and Company Tract Five Hundred Ninety-three (593) feet to the point of beginning; **EXCEPTING** the following described exception:

Attachment 2

EXCEPTION NO. 1 - BERGNER TRACT

A part of the South Half of the Southeast Quarter of Section Thirty-one (31) in Township One (1) South of the Base Line and in Range Eight (8) West of the Fourth Principal Meridian, Adams County, Illinois being more particularly bounded and described as follows to wit:
Commencing at a stone at the Southeast corner of said Southeast Quarter, thence North 89° 46' West along the South line of said Southeast Quarter One Thousand Two Hundred Thirty-four and Thirty-five Hundredths (1234.35) feet, thence North 00° 05' East Three Hundred Fifty-nine and Eighteen Hundredths (359.18) feet to the True Point of Beginning, thence from said True Point of Beginning North 89° 55' West Two Hundred Fifty-eight (258) feet, thence North 00° 05' East One Hundred Thirty-five and Forty Hundredths (135.40) feet, thence North 44° 55' West Seventy-seven and Ninety-four Hundredths (77.94) feet, thence North 45° 05' East Thirty-five and Fifty Hundredths (35.50) feet thence North 00° 05' East Fifty and Thirty-eight Hundredths (50.38) feet thence South 89° 55' East Two Hundred Sixty-eight (268) feet, thence South 00° 05' West Thirty (30) feet, thence South 33° 36' 25" East Thirty-six and Six Hundredths (36.06) feet, thence South 00° 05' West Two Hundred Six (206) feet to the point of beginning.

Tract II: (Bergner Tract)
A part of the South Half of the Southeast Quarter of Section 31 in Township 1 South of the Base Line and in Range 8 West of the Fourth Principal Meridian, Adams County, Illinois, being more particularly bounded and described as follows to wit:

Commencing at a stone at the Southeast corner of said Southeast Quarter, thence North 89 46' West along the South line of said Southeast Quarter 1234.35 feet, thence North 00 05' East 359.18 feet to the True Point of Beginning, thence from said True Point of Beginning North 89 55' West 258 feet, thence North 00 05' East 135.40 feet, thence North 44 55' West 77.94 feet, thence North 45 05' East 35.50 feet, thence North 00 05' East 50.38 feet, thence South 89 55' East 268 feet, thence South 00 05' West 30 feet, thence South 33 36' 25" East 36.06 feet, thence South 00 05' West 206 feet to the point of beginning, **said tract containing 1.649 acres.**

Tract III:
Non-exclusive Easements for Access, Ingress and Egress pursuant to Section 2.2A (other than the items referenced in Section 2.2A(i) and Section 2.2A(ii)); Non-exclusive Easements for Utilities pursuant to Section 2.3 and Rights of Abutment pursuant to Section 2.4 for the benefit of Tracts I and II as more particularly set forth in that certain Operating Agreement of record in Book 86 of Miscellaneous Records at Page 312, Document No. 25893.

Attachment 2

QUINCY MEDICAL GROUP

October 1, 2018

Mr. Michael C. Owens, CPA
Chief Investment Officer
President, Office and Medical Division
Cullinan Properties, Ltd.
420 North Main Street
East Peoria, IL 61611

Re: Intent to Lease
Property at 3347 Broadway Street, Quincy, IL

Dear Mr. Owens:

Quincy Medical Group intends to lease the property at 3347 Broadway Street, Quincy, Illinois. This property is the former Bergner's building. The re-use will be for medical services, including ambulatory surgery.

Terms and conditions of the lease will be negotiated and developed during the next two months.

The commitment to lease will be dependent on State of Illinois Certificate of Need and other regulatory approvals.

We look forward to the upcoming discussions with Cullinan Properties to establish terms and conditions and finalize the leasing arrangement.

Sincerely,

Carol Brockmiller

Carol Brockmiller, CMPE
Chief Executive Officer
Quincy Medical Group
1025 Maine Street
Quincy, IL 62301

Attachment 3 – Operating Identity/Licensee

Quincy Physicians & Surgeons Clinic, S.C., d/b/a Quincy Medical Group is physician owned and controlled.

At the time the permit application was filed, UnityPoint Health held approximately 40% of Quincy Medical Group's stock. The ownership percentage varies slightly as physicians enter and leave the practice. UnityPoint Health will have approximately 40% ownership interest in Quincy Medical Group Surgery Center.

Attachment 3 contains an Illinois Certificate of Good Standing for Quincy Physicians & Surgeons Clinic, S.C., d/b/a Quincy Medical Group.

Attachment 3

File Number 5448-637-5

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

QUINCY PHYSICIANS & SURGEONS CLINIC, S.C., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON DECEMBER 19, 1986, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE RELATING TO THE PAYMENT OF FRANCHISE TAXES, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 9TH *day of* OCTOBER *A.D.* 2018 .

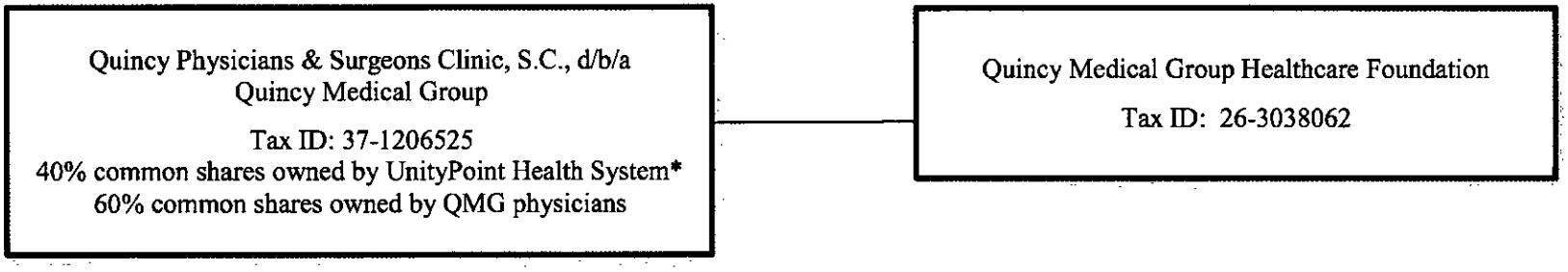
Authentication #: 1828201090 verifiable until 10/09/2019
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

Attachment 3

ORGANIZATIONAL CHART



*At the time the permit application was filed, UnityPoint Health held approximately 40% of Quincy Medical Group's common stock. The percentage varies slightly as physicians enter and leave the practice.

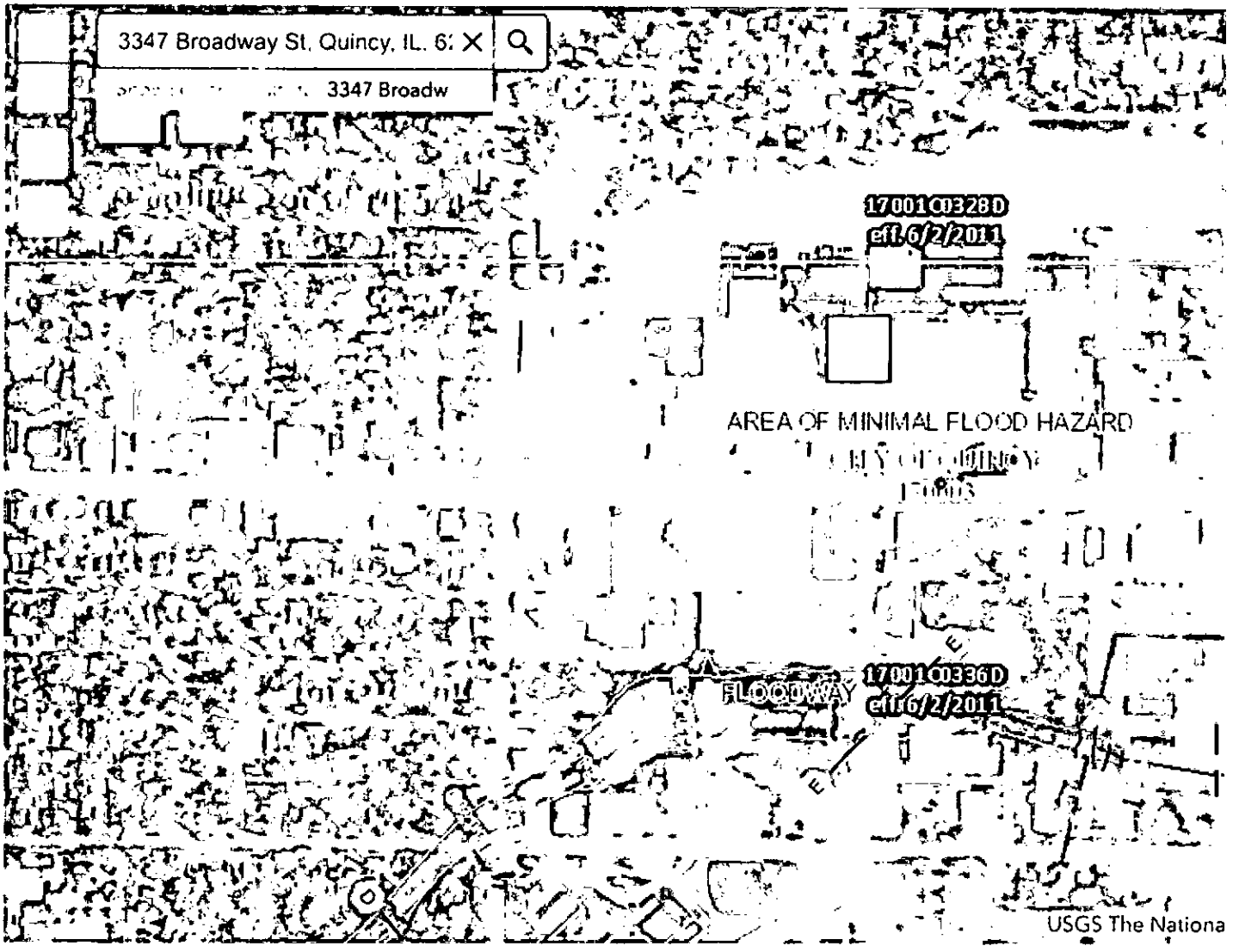
Attachment 4

September 2018

Attachment 5 – Flood Plain Requirements

The project site at 3347 Broadway Street is located in an "Area of Minimal Flood Hazard," as shown in Attachment 5 and outlined in red. The site is located in panel 17001C0336D on the FEMA map. Therefore, the project is in compliance with the requirements of Illinois Executive Order #2006-5.

Attachment 5


3347 Broadway St, Quincy, IL, 6
3347 Broadw
17001C0328D
eff.6/2/2011
AREA OF MINIMAL FLOOD HAZARD
17001C0336D
eff.6/2/2011
FLOODWAY
USGS The Nationa

600ft

Attachment 6 – Historic Resources Preservation Act Requirements

Attached is a September 18, 2018 letter requesting confirmation of compliance with the requirements of the Historic Resources Preservation Act. The applicant will forward the response from the Historic Preservation Agency upon receipt.

Attachment 6

September 18, 2018

Ms. Rachel Leibowitz, Ph.D.
Deputy State Historic Preservation Officer
Illinois Department of Natural Resources
One Natural Resources Way
Springfield, IL 62702-1271

Re: CON – Ambulatory Surgical Treatment Center
Quincy Medical Group
3347 Broadway Street
Quincy, Illinois 62301

Dear Dr. Leibowitz:

Quincy Medical Group ("QMG") is preparing a Certificate of Need permit application to establish an ambulatory surgical treatment center in Quincy, Illinois. The chosen location for the project is 3347 Broadway Street in Quincy, Illinois. The property is currently occupied by a shopping center. If the project is approved by the Illinois Health Facilities and Services Review Board, QMG intends to re-purpose the facility for healthcare use.

Attached is a map of the location, and the street view of the location as viewed from Broadway Street (facing north).

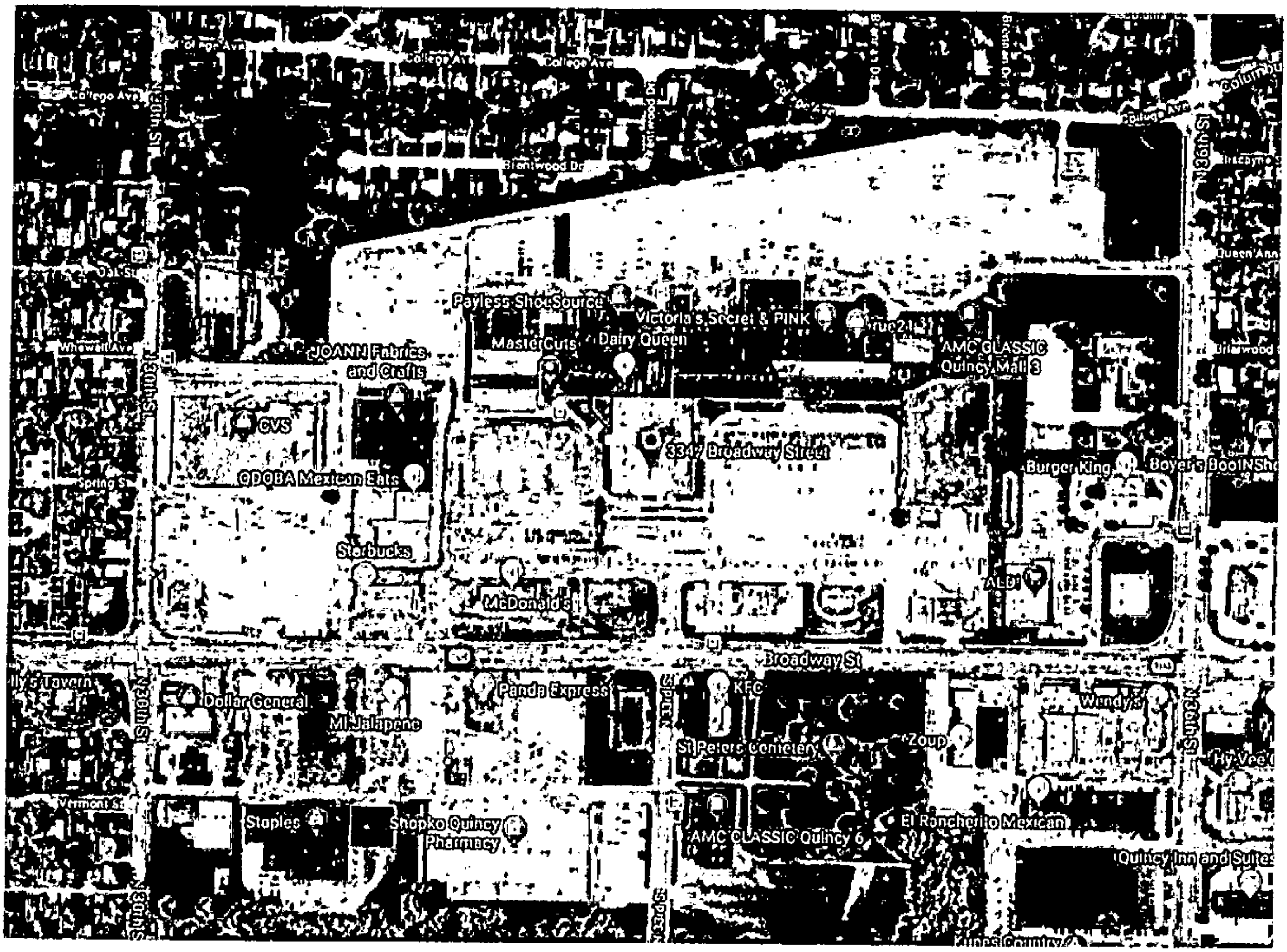
I represent QMG as its Certificate of Need consultant. Please provide me with a letter concerning the applicability of the Preservation Act to the proposed projects. I will include your letter in the Certificate of Need permit application.

Thank you for your attention to this request.

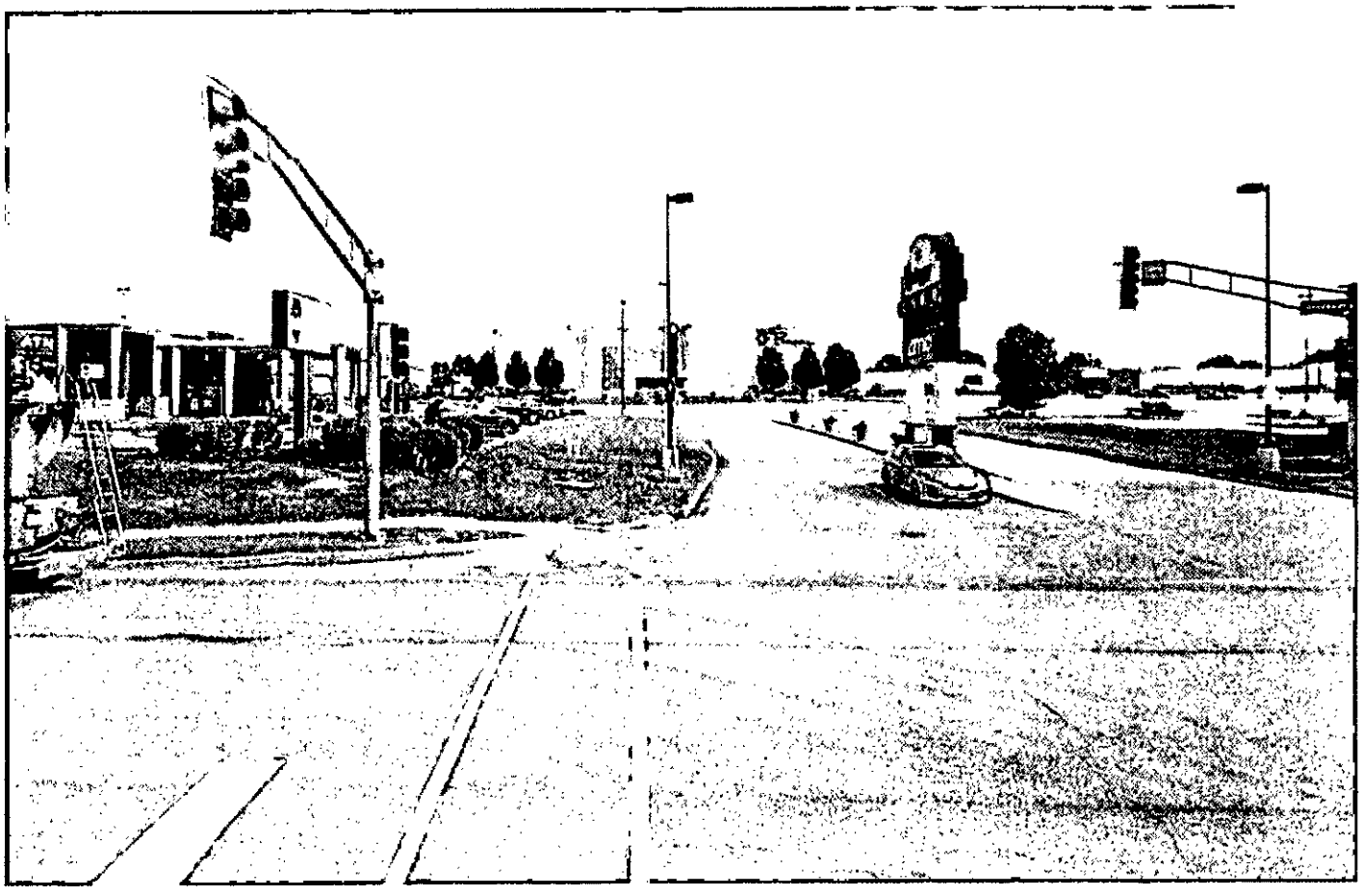
Sincerely,

Ralph M. Weber
Weber Alliance
920 Hoffman Lane
Riverwoods, IL 60015
rmweber90@gmail.com
847-791-0830

Attachments:
Satellite Map
Street View of Structure



Attachment 6



PROJECT COSTS AND SOURCES OF FUNDS

	Clinical	Non-Clinical	Total
Use of Funds			
Pre-Planning Costs	55,584	13,896	69,840
Site Survey and Soil Investigation*			-
Site Preparation*			-
Off-Site Work*			-
Modernization contracts*			-
New Construction contracts*			-
Contingencies*			-
A/E fees*	20,083	5,021	25,104
Consultant fees	352,291	88,073	440,364
Movable Equipment	4,456,026	394,716	4,850,742
Bond Issuance Expense			-
Net Interest Expense during const*			-
FMV Leased space or equipment			-
Leased Space	8,575,924	3,302,516	11,878,440
Leased Equipment	944,928		944,928
Other capital costs - IT	750,000	335,000	1,085,000
Other capital costs - Artwork		125,000	125,000
Other capital costs - Signage		100,000	100,000
Acquisition of Building			-
Total Uses of Funds	15,154,836	4,364,222	19,519,058
			-
Source of Funds			-
Cash and Securities	1,469,163	297,933	1,767,096
Pledges			-
Gifts and Bequests			-
Cond Issues (project related)			-
Mortgages	4,164,820	763,773	4,928,593
Leases (fair market value)	9,520,852	3,302,516	12,823,368
Governmental Appropriations			
Grants			
Other Funds and Sources			
Total Sources of Funds	15,154,836	4,364,222	19,519,058

Note: Site Survey and Soil Investigation, Site Preparation, Off-Site Work, New Construction Contracts, Contingencies, and the bulk of A/E fees and Net Interest Expense During Construction are included in the Fair Market Value of the lease of space.

Attachment 7 – Itemization of Project Costs and Sources of Funds

The table on the preceding page lists all costs associated with the project.

Itemization of each line item noted in the table is provided below:

Preplanning Costs
$69,480

Costs include consulting fees related to the development of financial feasibility studies and detailed pro forma of the project.

Architect/Engineering Fees
$25,104

This work includes consultation services, preliminary building analysis, program development and preliminary floor layouts with adjacencies. Schematic design, design development, and construction documents will be the responsibility of the building owner; costs of these A/E services will be incorporated into the lease payments.

Consultant Fees
$440,364

Costs include strategic planning, legal consultation, certificate of need application preparation, other regulatory planning, and permit application fees.

Moveable Equipment
$4,850,742

Clinical Equipment	**$4,456,026**
ASTC Equipment	$2,542,508

ASTC Moveable Clinical Equipment includes anesthesia machines, surgical lights, patient monitors, instrument sterilizers, stretchers, surgical tables, video systems, glaucoma laser system and phacoemulsifier for ophthalmology, and instruments for each surgical specialty that the ASTC serves. Additional surgical equipment is to be obtained by lease, and is described below. The FMV of this leased equipment for the 7 surgical and procedure rooms totals $944,928. Consequently, the total value of equipment for the 7 rooms is $3,487,436. The 8th room is to function as a catheterization service; its equipment costs are separated from the surgical room costs, as reported below.

Cath Equipment	$1,247,143

Cath Moveable Clinical Equipment includes a fixed C-arm, hemo system, cardiac ultrasound, anesthesia machine, patient monitors, stretchers, surgical light source, procedure table and table drapery radiation shield.

CT Equipment $666,375

CT Moveable Equipment includes a CT machine, installation, and room supplies.

Non-Clinical Equipment $394,716

Moveable Non-Clinical Equipment includes chairs, tables, desks, staff break room furniture and appliances, copiers, office equipment, and shelving.

FMV of Leased Equipment
$944,928

This equates to the fair market value of leased ASTC clinical equipment which includes two (2) C-Arm machines and endoscopy scopes and related system support equipment. This amount added to the cost of the Moveable ASTC Clinical Equipment is $3,487,436.

FMV of Leased Space
$11,878,440

This equates to the fair market value of the lease for space for the project.

Other Capital Costs
$1,085,000

Clinical IT Costs $750,000

This includes Epic software system build and training.

Non-Clinical IT Costs $335,000

These costs include IT network and desktop hardware and installation and communications system and installation.

Other Capital Costs – Artwork $125,000

Cost of artwork for the new facility.

Other Capital Costs – Signage $100,000

Cost of signage for the new facility.

Attachment 8 – Financial Commitment

Financial commitment will occur after permit issuance.

Attachment 8

Cost Space Requirements (Departmental Sq. Ft.)

Department/Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Sq Ft That Is:			
		Existing	Proposed	New Const	Modernized	As Is	Vacated
CLINICAL/REVIEWABLE							
Surgery							
ORs and support			10,240	10,240			
Procedure rms and support			2,410	2,410			
Recovery			3,685	3,685			
Cardiac Catheterization			1,500	1,500			
CT Scanner			1,550	1,550			
Subtotal Clinical			19,385	19,385			
NON-REVIEWABLE							
Lobby, reception, waiting			1,690	1,690			
Public toilets, family room			500	500			
Lockers and lounge			925	925			
Storage			781	781			
Conference room			630	630			
Medical records			545	545			
Mech, bldg syst, hskeep			978	978			
Circulation			1,416	1,416			
Subtotal Non-Clinical			7,465	7,465			
TOTAL CONSTRUCTION *			26,850	26,850		900	
Other Proj Costs							
Preplanning Costs	$69,480						
Site Survey / Soil *							
Site Preparation *							
Off Site Work *							
Contingencies *							
A/E fees *	25,104						
Consulting, fees	440,364						
Moveable Equipt, Furnish	4,850,742						
Bond Issuance Expense							
Net Int Exp Dur Constr *							
FMV leased space, eqpmnt							
- space	11,878,440						
- equipment	944,928						
Other Capital Costs							
- IT	1,085,000						
- artwork	125,000						
- signage	100,000						
Subtotal	19,519,058						
TOTAL PROJECT COSTS	$19,519,058						

Notes:

1. Costs (*): Site Survey and Soil Investigation, Site Preparation, Off-Site Work, New Construction Contracts, Contingencies, the bulk of A/E fees, and Net Interest Expense During Construction are included in the FMV of leased space.

2. Space: The building accommodates 26,850 sq ft for the project's ASTC, cardiac cath service and CT scanner. The planned radiation oncology and infusion therapy services are not subject to CON review and are not included in the permit application. The building also includes vacant unused space that is not part of the project.

Attachment 11 – Background of the Applicant

1. **A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.**

Name	Address	Type
Quincy Medical Group – Main Campus	1025 Maine St., Quincy, IL 62301-4038	Medical Office Practice
Quincy Medical Group – Main Campus	1118 Hampshire St., Quincy, IL 62301-3027	Medical Office Practice
Quincy Medical Group – Main Campus	1101 Maine St., Quincy, IL 62301	Medical Office Practice
Quincy Medical Group - Barry Affiliate	868 Mortimer, Barry, IL 62312-1249	Medical Office Practice
Quincy Medical Group - Canton Affiliate	1100 E. Outer Rd., S., Suite 4 Canton, MO 63435-1702	Medical Office Practice
Quincy Medical Group – ENT	1107 College, Suite 2, Quincy, IL 62301-2600	Medical Office Practice
Quincy Medical Group - Eye and Vision Institute	1125 Hampshire St., Quincy, IL 62301	Medical Office Practice
Quincy Medical Group - HQ Eyes	175 Shinn Lane, Hannibal, MO 63401-6754	Medical Office Practice
Quincy Medical Group - Kahoka Affiliate	133 East Main St., Kahoka, MO 63445-1775	Medical Office Practice
Quincy Medical Group - Keokuk Affiliate	1603 Morgan St., Suite 3, Keokuk, IA 52632-3433	Medical Office Practice
Quincy Medical Group - LaBelle Affiliate	1000 Central St., LaBelle, MO 63447-2092	Medical Office Practice
Quincy Medical Group - Lewistown Affiliate	105 E. Quincy St., Lewistown, MO 63452-2560	Medical Office Practice
Quincy Medical Group - Mt. Sterling Affiliate	521 E. Main St., Mt. Sterling, IL 62353-1378	Medical Office Practice
Quincy Medical Group - Cancer Care	1005 Broadway, Quincy, IL 62301-2834	Medical Office Practice
Quincy Medical Group - Oral & Maxillofacial Surgery	3915 Maine St., Suite 3, Quincy, IL 62305	Medical Office Practice

Quincy Medical Group - Pleasant Hill Affiliate	405 E. State St., Pleasant Hill, IL 62366-2424	Medical Office Practice
Quincy Medical Group - Pittsfield Affiliate	320 N. Madison, Pittsfield, IL 62363-1412	Medical Office Practice
Quincy Medical Group - Podiatry	3740 E. Lake Centre, Quincy, IL 62305-5805	Medical Office Practice
Quincy Medical Group - Winchester Affiliate	231 W. Cherry St., Winchester, IL 62694-1027	Medical Office Practice
Blessing Hospital ASTC*	1118 Hampshire St., Quincy, IL 62301	Ambulatory Surgery Center

***Quincy Physicians & Surgeons Clinic, S.C., d/b/a Quincy Medical Group owns the land and building but is not the operator of the license.**

2. A listing of all health care facilities currently owned and/or operated in Illinois, by any corporate officers or directors, LLC members, partners, or owners of at least 5% of the proposed health care facility.

Not applicable.

3. For the following questions, please provide information for each applicant, including corporate officers or directors, LLC members, partners and owners of at least 5% of the proposed facility. A health care facility is considered owned or operated by every person or entity that owns, directly or indirectly, an ownership interest.

a. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant, directly or indirectly, during the three years prior to the filing of the application.
b. A certified listing of each applicant, identifying those individuals that have been cited, arrested, taken into custody, charged with, indicted, convicted or tried for, or pled guilty to the commission of any felony or misdemeanor or violation of the law, except for minor parking violations; or the subject of any juvenile delinquency or youthful offender proceeding. Unless expunged, provide details about the conviction and submit any police or court records regarding any matters disclosed.
c. A certified and detailed listing of each applicant or person charged with fraudulent conduct or any act involving moral turpitude.
d. A certified listing of each applicant with one or more unsatisfied judgements against him or her.
e. A certified and detailed listing of each applicant who is in default in the performance or discharge of any duty or obligation imposed by a judgment, decree, order or directive of any court or governmental agency.

See attached letter.

4. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**

See attached letter.

5. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest that the information was previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

Not applicable.

QUINCY MEDICAL GROUP

October 12, 2018

Ms. Courtney Avery
Administrator
Illinois Health Facilities and
Services Review Board
525 West Jefferson Street - 2nd Floor
Springfield, IL 62761

Dear Ms. Avery:

As Chief Executive Officer of Quincy Medical Group, I hereby certify that no adverse action has been taken against Quincy Medical Group, directly or indirectly, within three years prior to the filing of this application. For the purpose of this letter, the term "adverse action" has the meaning given to it in the Illinois Administrative Code, Title 77, Section 1130.

I hereby authorize the Health Facilities and Services Review Board and IDPH to access any documentation which it finds necessary to verify any information submitted, including but not limited to: official records of IDPH or other State agencies and the records of nationally recognized accreditation organizations.

If you have any questions, please contact me at 217 222-6550 x 6455.

Sincerely,

Carol Brockmiller

Carol Brockmiller, CMPE
Chief Executive Officer
Quincy Medical Group
1025 Maine Street
Quincy, IL 62301

Attachment 12 – Purpose of Project

Quincy Medical Group (QMG) has been serving the population of western Illinois, southeast Iowa, and eastern Missouri for more than 80 years. QMG is the fourth largest employer in Adams County. The large multi-disciplinary practice has 115 physicians, 40 advanced physician practitioners, and over 875 employees. Through its 12 office locations, it serves a population of 400,000 people, and is a significant source of high quality primary, specialty, and sub-specialty rural health care. (See attached map, labeled as Attachment 12A.) It is physician-owned and governed; all eight members of its board are physicians. QMG's principal offices are located at 1025 Maine Street in Quincy, Illinois. QMG owns the land and buildings on this campus, including medical office buildings, administration, and the Blessing Hospital ASTC at 1118 Hampshire. Many QMG physicians maintain leadership roles in several departments at Blessing Hospital and provide coverage for its emergency room and contracted services, such as intensive care units.

QMG affiliated with UnityPoint Health, a not-for-profit health system, in 2012. The two share a vision of providing high quality affordable health care. QMG is responsible for 10,000 of the 85,000 covered Medicare lives in UnityPoint's Accountable Care Organization's (ACO) Medicare NextGen contract. The ACO also participates in commercial value-based contracts, adding additional lives. ACOs were set up across the country to implement the Affordable Care Act, and to incentivize providers to be responsible for the health of defined populations by delivering high quality care through cost effective processes and in cost effective settings. The proposed project will enable QMG to offer patients, employers, and insurers high quality care in cost effective settings, resulting in care delivery efficiency and savings to the community and payors.

As a for-profit entity, all earnings retained by QMG are subject to federal and state corporate income tax. From 2013 - 2017, QMG paid on average $1,045,874 in federal income tax and $320,967 in state income tax per year, totaling more than $6.8 million paid in taxes, which is a significant source of government revenue. QMG also pays property tax on all property owned by QMG, and property taxes will be paid on the building and/or property that houses the proposed project. From 2016 – 2018, QMG paid more than $2 million in property taxes. The capital investment by QMG will bring tax dollars to the Quincy community. The building where the project will be located generates approximately $64,000 in taxes per year. In addition, earnings distributed to QMG physicians are also subject to federal and state personal income tax.

1. **Document that the project will provide health services that improve the health care or well-being of the market area population to be served.**

Health services to be delivered through the project include ambulatory surgery and cardiac catheterization. Ambulatory surgery services include the following: cardiovascular, colon and rectal surgery, gastroenterology, general surgery, neurological surgery, obstetrics/gynecology, ophthalmology, oral/maxillofacial surgery, orthopedic surgery, otolaryngology, plastic surgery, podiatric surgery, urology, and pulmonology.

The purpose of this project is to increase accessibility to high-quality, lower cost ASTC and cardiac catheterization health services and expand the scope of those health services available to QMG existing patients and residents of Quincy and the surrounding areas.

More types and volumes of surgery are increasingly being provided in hospital outpatient settings. ASTCs provide high quality surgical care and a high level of patient satisfaction at a lower cost than hospital outpatient settings. A 2016 study from the Ambulatory Surgery Center Association estimates that $37.8 billion is saved annually by utilizing ASTCs as opposed to hospital outpatient departments.[1] This is enabled by advancements in technology and anesthesia, medications and protocols, lower cost, reimbursement incentives, and, importantly, patient preferences. Outpatient settings deliver high quality care and often are more efficient than hospital operating suites that end up prioritizing inpatient and emergency cases over procedures than can be more effectively provided in outpatient settings.

QMG will charge ASTC rates, averaging more than 30% lower per procedure compared to hospital outpatient rates. Further, analysis shows that for the top ten surgical procedures to be performed in the proposed ASTC on Medicare patients, total savings would be $2.3 million per year at a minimum, and at least $4 million per year for all procedures performed in the proposed ASTC. A similar percentage of savings would also be achieved for commercial, Medicaid, and worker's compensation patients.

Appendix A contains two timely articles commenting on the proposal of CMS (Centers for Medicare and Medicaid Services) to include cardiac caths in the list of ASTC approved services and two articles regarding quality care and cost savings in ASTCs.

2. Define the planning area or market area, or other relevant area, per the applicant's definition.

The table attached as Attachment 12B shows patient origin data for all QMG patients, and, as shown in the map attached as Attachment 12C, 70% of QMG patients reside in the top 17 zip codes. The map further demonstrates the classic diffusion of zip codes characteristic of downstate rural and semi-rural areas. They are not contiguous, but, rather, reflect more the centers of population in smaller towns. The zip codes do not define a concentrated planning area, and neither does the 25-mile radius as several (8 of the top 17 zip codes) lie beyond the radius. QMG often refers to its "Service Area" as a larger area with a 50-mile radius, which resolves the issues of diffusion and non-contiguity of zip codes.

As a result, the Planning Areas for this project are GSA for ambulatory surgery and HSA 3 for cardiac catheterization.

3. Identify the existing problems or issues that need to be addressed as applicable and appropriate for the project.

[1] Study: June 14, 2016, Commercial Insurance Cost Savings in Ambulatory Surgery Centers. https://www.ascassociation.org/advancingsurgicalcare/reducinghealthcarecosts/costsavings/healthcarebluebookstudy .

There are numerous problems and/or issues that will be addressed and/or remedied with the proposed project, including the following:

- **Access**. Currently, there is only one other ASTC in Adams County.. However, the operational practice at the existing ASTC drastically limits available surgery hours as the anesthesiology group retained by the owner ofthe ASTC usually does not allow surgical cases to begin after 3 p.m. This limitation significantly impacts the ability of QMG surgeons to perform procedures for their patients, including those who wish to perform procedures during the evening hours. QMG desires to have the flexibility to control and expand surgery hours to include evenings and weekends for patient convenience.
- **Cost of Care.** QMG has many incentives driving the need to reduce costs and deliver high quality efficient care at affordable prices. ACOs require value based care for defined population groups. This means that providers in ACO arrangements are responsible for the health care of their enrolled Medicare and commercial insured populations. ACO providers are incentivized to control costs without sacrificing quality, and achieve outcome measurements. QMG is not able to offer lower cost services when facility charges for outpatient surgeries performed by QMG physicians are based on HOPD rates, as is the current situation with Quincy's existing ASTC. Owning and controlling its own outpatient surgery and cath facility, as in the proposed project, will enable QMG to pass along savings of approximately 30% due to the differential between hospital outpatient and ASC charges. This will make the ACO more cost effective and lower the cost of care in the region, consistent with the goals of the Affordable Care Act. The evolving health care delivery system mandates more cost effective models of care.
- **Outmigration of Orthopedic Cases.** There is a large outmigration of Quincy area residents for orthopedic surgery. Over the past three years, 2,054 patients have received care in Springfield, St Louis, and other locations outside of the Quincy area. QMG believes that many of these cases were directed by insurers or employers seeking beneficial pricing not available locally, or by patients seeking a greater choice of providers.
- **Lack of Patient Choice.** While there are 5 ASTCs in HSA 3, 4 of the 5 are located in or around Springfield and only 1 is located in Adams County. The map included as Attachment 12D highlights the inadequacy. QMG seeks to increase accessibility to ASTC services, in general, to Quincy and the surrounding areas, which will ultimately increase patient choice.
- **Lack of ASTC Availability for Urological Services and ENT Related Procedures and Limited Neurosurgery Services.** While the State profile for Quincy's existing ASTC lists urology as a surgical service, the volumes are miniscule: 3 cases in 2016, 3 in 2015, and 1 in 2014. Urology equipment is not available in the existing ASTC; therefore, outpatient urological surgery is performed in the local hospital's ORs. Lack of ASTC availability for these cases is a dissatisfier for both patients and providers. In contrast, QMG projects a large volume of outpatient urological cases in the proposed ASTC to serve community

need. Currently, limited neurosurgery procedures are performed in Quincy's existing ASTC. In 2019, a third neurosurgeon will join QMG, and QMG will have the ability and opportunity to perform new procedures in the proposed ASTC. QMG will also provide certain ENT equipment in the ASTC, which is currently only offered by the local hospital in its outpatient department, thereby allowing related procedures to be performed in the ASTC setting,

- **Lack of Immediate Access to QMG Patient's Complete Medical Record.** QMG physicians do not have immediate access to the complete medical record of their patients when performing services at Quincy's existing ASTC, and, as a result, QMG physicians are required to navigate two electronic medical record (EMR) systems.

4. Cite the sources of the documentation.

- 2014 IRS Estimated Population data
- QMG's medical record, Epic, using Microsoft Business Objects BI Launchpad
- HFSRB Inventory of Hospital Services and Need Determinations
- HOPD to ASC Conversion: Now or Later with Transition to Value Based Care. Undated white paper, by Regent Surgical Health.
- CMS Pitches Covering Cardiac Catheterization at Surgical Centers, MedTechDive, July 30, 2018, Susan Kelly
- Cardiovascular Procedures 2019: Is the Future Here? Cath Lab Digest, Volume 26, Issue 9, September 2018. Marc Toth.
- Study: June 14, 2016, Commercial Insurance Cost Savings in Ambulatory Surgery Centers,https://www.ascassociation.org/advancingsurgicalcare/reducinghealthcarecosts/costsavings/healthcarebluebookstudy.
- ASCs: A Positive Trend in Health Care, Advancing Surgical Care, https://www.ascassociation.org/advancingsurgicalcare/aboutascs/industryoverview/apositivetrendinhealthcare.

5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.

The opportunity for cost savings at an ASTC owned and operated by QMG is dramatic and real. Many of the hospital sponsored ASTCs now in operation base their charges on hospital outpatient department (HOPD) rates, with little difference in the cost between outpatient cases done in a hospital surgical department, and outpatient cases in an ASTC. According to Regent Surgical Health, one of the largest operators of surgical centers in the United States, hospitals received an 81% higher reimbursement rate on services performed in the HOPD over those in an ASTC. As health care economics shifts from maximizing revenues to value-based care, the lower ASTC rates will prevail in a cost competitive market.

The table in this section lists QMG's top ten surgical procedures performed on Medicare patients that are ASC (Ambulatory Surgery Center) eligible. The 2018 Medicare area adjusted facility reimbursement rates in an ASC and in a HOPD are shown in the two columns to the right of the surgical procedure. For example, the rate for a colonoscopy is $451 in the ASC compared

to $849 in the hospital outpatient department (HOPD). When the per-case savings for each of these top 10 services are multiplied by year 2017 QMG actual case volumes, the ASC achieves savings of $2.3 million dollars. In the ASC setting, these services cost $2.6 million, compared to $4.9 million in the hospital setting.

That $2.3 million savings is only for the top ten ASC eligible Medicare cases, based upon the primary procedures performed in a case, and without consideration of multiple procedures, which would result in even greater savings. When all Medicare cases are included, the projected savings is $4.0 million. Costs in the ASC for 4,689 estimated Medicare actual cases are projected at $4.5 million, compared to HOPD costs of $8.5 million. The complete and detailed table of CPT codes, rates, and aggregated savings for all Medicare cases is shown in Appendix B at the end of this application. The aggregate savings in the ASC is a significant reduction in cost of 47%.

$4.0 million is the savings in one year. Over ten years, that is a savings of $40.0 million, achieved by the shift to a lower cost delivery setting afforded by the ASTC. As more cases are approved by CMS for the ASC list, and as the Medicare population grows, the savings is also expected to grow at an increased rate compared to prior experience reflected in the table in this section and Appendix B.

This analysis, limited to Medicare patients only, demonstrates the cost effectiveness of the proposed ASTC. 50% of QMG's patients are Medicare. Similar savings are achieved by QMG's patients covered by private insurance, workers comp and Medicaid. This savings will accrue to Quincy area employers and employees, resulting in lower co-pays, coinsurance and overall total cost of surgical care for all individuals receiving outpatient surgical services at QMG.

As part of its ongoing efforts to facilitate the transition of appropriate clinical care from the inpatient to outpatient settings, CMS is proposing to add cardiac catheterization to its approved list for treatment in ambulatory surgery centers. Two current articles are included in Appendix A of this permit application:

"CMS pitches covering cardiac catheterization at surgical centers," by MedTechDive, Susan Kelly, July 30, 2018.

"Cardiovascular Procedures 2019: Is the Future Here?" by Martin Toth, Cath Lab Digest; vol 26, Issue 9, September 2018.

The latter source includes the following statement: "The history and evolution of the ASC has favored an expanding scope of service. As operators, tools, and technology have advanced, the ASC has consistently become a safer and more cost-effective site of service for procedures. In addition to venous and dialysis vascular access work, the cardiovascular procedure outpatient shift accelerated with the migration of electrophysiology implantable procedures and PAD procedures to the outpatient site of service. The continuing advancement of minimally invasive services into the ASC is evident with the proposed addition of diagnostic coronary caths for 2019."

The proposed project anticipates this rule change by CMS and incorporates a catheterization service in the ASTC as an opportunity for the provision of this care in a cost effective and efficient facility setting.

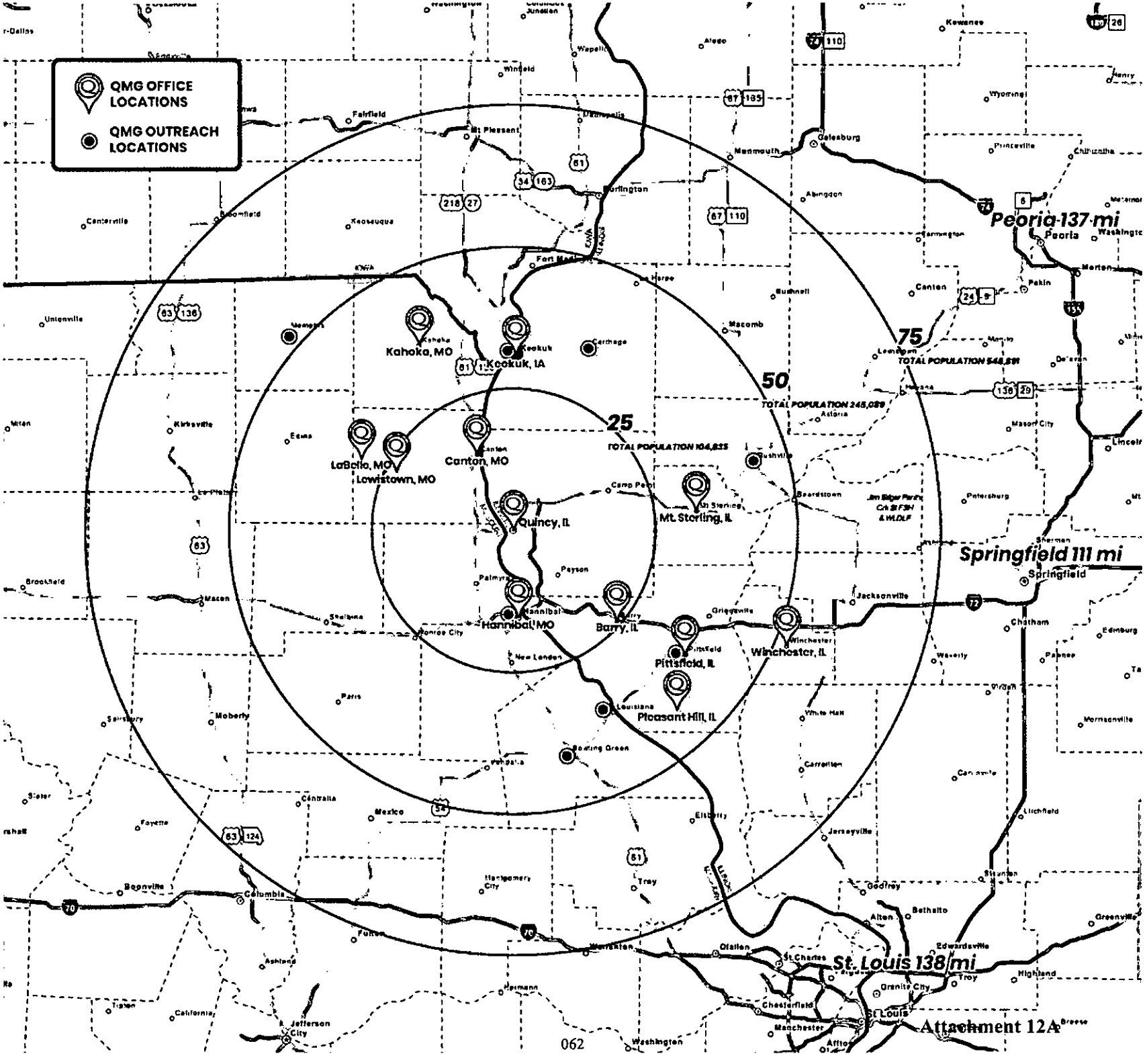
To the extent that orthopedic cases are being referred out of the area to take advantage of competitive pricing, the proposed project will reduce the cost and charges for ambulatory surgery cases, including orthopedics. Having a facility with one of the ORs used mostly for orthopedic cases will help recruit more specialized orthopedic surgeons that will help retain patients in the local area.

The proposed ASTC will also improve care coordination, efficiency, and lead to better clinical outcomes as QMG physicians will have immediate access to a patient's complete medical record through QMG's EMR system and will not be required to navigate two EMR systems (that of the local hospital provider and that of QMG).

The proposed ASTC will be beneficial to the Quincy community and will not adversely impact other local providers. Additionally, due to the existing maldistribution of ASTC facilities, as shown in the map on Attachment 12D, the proposed ASTC will not result in an unnecessary duplication of services, but will, in fact, correct existing maldistribution issues.

6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals as appropriate.

QMG's objectives are to increase and enhance accessibility to ASTC for its patients and residents of Quincy and the surrounding communities and improve the quality of these health services. QMG seeks to reduce the cost of surgical services and catheterizations by 30%. QMG intends to complete the project by March 1, 2021.



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Attachment 12A

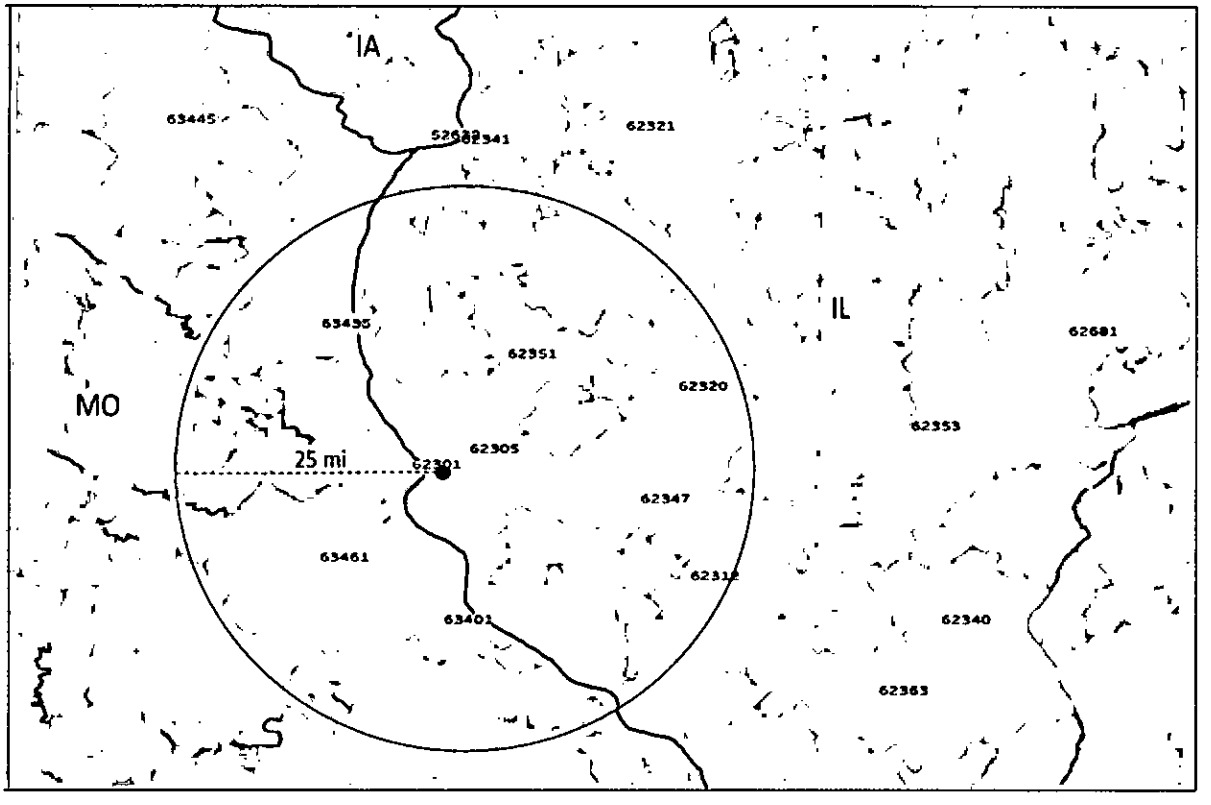
Table: Patient Origin, All QMG patients

Zip Code	Community Name	Population (2014)	QMG Patients (2017)	% of Total	Cumulative %
62301	Quincy IL	27620	21352	22.29%	22.29%
62305	Quincy IL	18110	13520	14.11%	36.40%
63401	Hannibal MO	18700	4595	4.80%	41.20%
62363	Pittsfield IL	5110	3798	3.96%	45.16%
52632	Keokuk IA	10860	3760	3.93%	49.09%
62353	Mt Sterling IL	3190	2519	2.63%	51.72%
63435	Canton MO	3120	2001	2.09%	53.81%
63461	Palmyra MO	5180	1830	1.91%	55.72%
62347	Liberty IL	2250	1564	1.63%	57.35%
62312	Barry IL	1790	1508	1.57%	58.92%
62681	Rushville IL	4530	1414	1.48%	60.40%
62320	Camp Point IL	1990	1385	1.45%	61.85%
62351	Mendon IL	1620	1240	1.29%	63.14%
62341	Hamilton IL	3150	1230	1.28%	64.43%
63445	Kahoka MO	3270	1162	1.21%	65.64%
62321	Carthage IL	3590	1129	1.18%	66.82%
62340	Griggsville IL	1520	1104	1.15%	67.97%
	Subtotal	115600	65111	67.97%	67.97%

Zip Code	Community Name	Population (2014)	QMG Patients (2017)	% of Total	Cumulative %
62360	Payson IL	1630	1099	1.15%	69.12%
62338	Fowler IL	1400	1024	1.07%	70.19%
62366	Pleasant Hill IL	1200	904	0.94%	71.13%
62376	Ursa IL	1210	881	0.92%	72.05%
63459	New London MO	3740	872	0.91%	72.96%
63456	Monroe City MO	3730	847	0.88%	73.84%
62379	Warsaw IL	1790	838	0.87%	74.72%
63448	La Grange MO	1380	824	0.86%	75.58%
63452	Lewistown MO	1000	820	0.86%	76.43%
63440	Ewing MO	1200	805	0.84%	77.27%
62324	Clayton IL	1200	743	0.78%	78.05%
63447	La Belle MO	900	687	0.72%	78.77%
62694	Winchester IL	2850	619	0.65%	79.41%
61455	Macomb IL	13050	591	0.62%	80.03%
63454	Maywood MO	870	506	0.53%	80.56%
62339	Golden IL	810	480	0.50%	81.06%
63334	Bowling Green MO	5830	476	0.50%	81.56%
62355	Nebo IL	680	475	0.50%	82.05%
62378	Versailles IL	820	444	0.46%	82.52%
63353	Louisiana MO	4130	433	0.45%	82.97%
62618	Beardstown IL	7680	411	0.43%	83.40%
62349	Loraine IL	580	405	0.42%	83.82%
62314	Baylis IL	530	386	0.40%	84.22%
62343	Hull IL	610	372	0.39%	84.61%
62365	Plainville IL	540	362	0.38%	84.99%
62356	New Canton IL	410	328	0.34%	85.33%
62311	Augusta IL	750	323	0.34%	85.67%
62354	Nauvoo IL	1300	309	0.32%	85.99%
63471	Taylor MO	540	298	0.31%	86.30%
62316	Bowen IL	580	286	0.30%	86.60%
62367	Plymouth IL	1080	266	0.28%	86.88%
62325	Coatsburg IL	370	264	0.28%	87.15%
63468	Shelbina MO	2410	262	0.27%	87.43%
62361	Pearl IL	450	261	0.27%	87.70%
63438	Durham MO	380	252	0.26%	87.96%
62370	Rockport IL	360	247	0.26%	88.22%

62650	Jacksonville IL	20770	240	0.25%	88.47%
62326	Colchester IL	2160	232	0.24%	88.71%
62375	Timewell IL	320	226	0.24%	88.95%
63463	Philadelphia MO	610	217	0.23%	89.18%
62345	Kinderhook IL	280	201	0.21%	89.39%
62373	Sutter IL	280	165	0.17%	89.56%
63457	Monticello MO	250	143	0.15%	89.71%
62306	Quincy IL	329	121	0.13%	89.83%
62359	Paloma IL	165	92	0.10%	89.93%
62348	Lima IL	102	25	0.03%	89.96%
63467	Saverton MO	85	15	0.02%	89.97%
	Other Zip Codes within Service Area	279564	7162	7.48%	97.45%
	Other Zip Codes Outside Service Area		2445	2.55%	100.00%
	Subtotal	**372905**	**30684**	32.03%	
	Grand Total	**488505**	**95795**		

TOP 17 ZIP CODES OF QMG PATIENTS RESIDENCE



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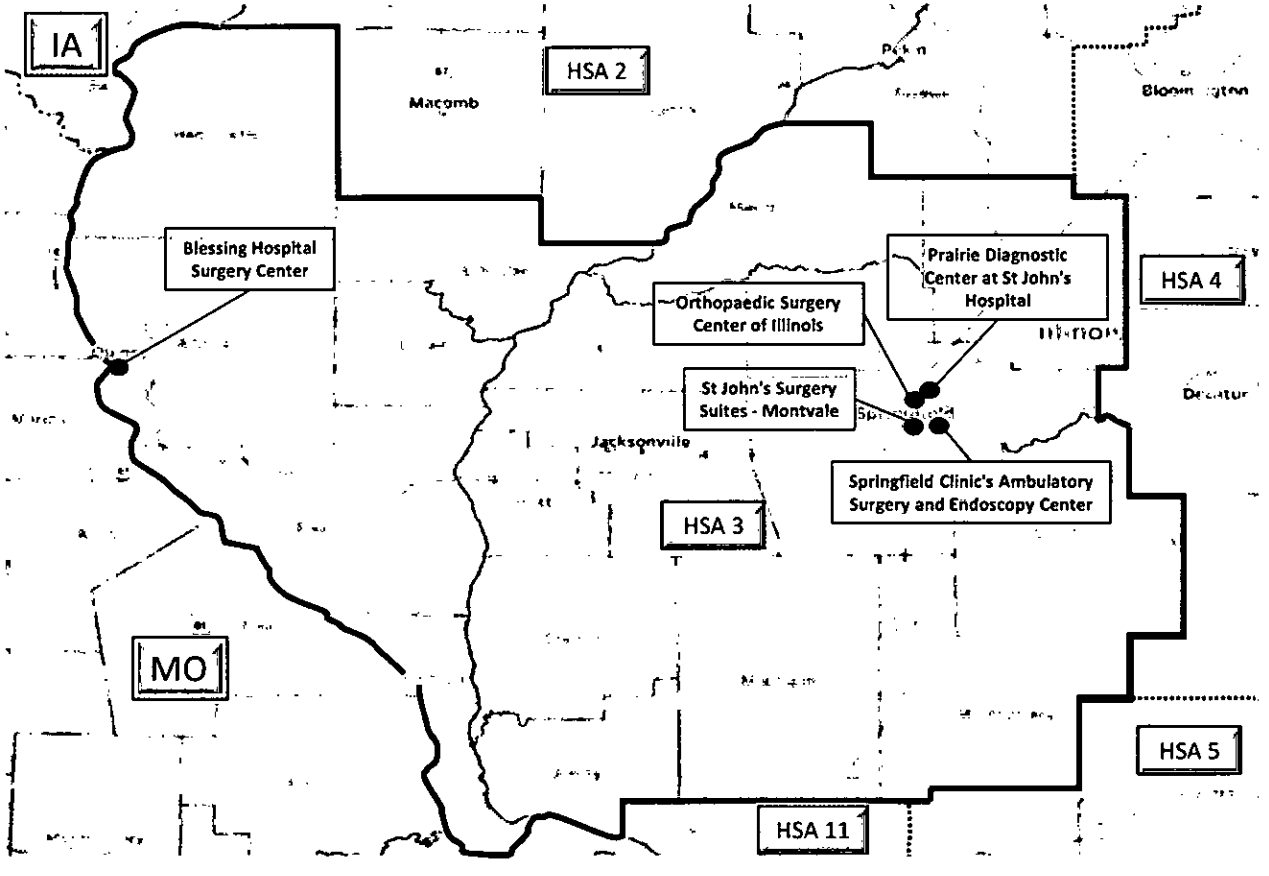
Attachment 12C

ASTCs in HSA 3



Attachment 12D

Attachment 13 – Alternatives

The proposed project is the optimal alternative when balancing costs, quality, and accessibility. The project will establish an 8-room ASTC in an existing vacant retail building at 3347 Broadway in Quincy. There will be 5 ORs and 3 procedure rooms, and 1 of the ORs will be dedicated to cardiac catheterization.

The following alternatives were considered before the decision was made to select the proposed project:

1. Modify the existing lease arrangement for the existing ASTC at 1118 Hampshire, in a building owned by Quincy Medical Group (QMG) on the QMG campus.

2. Undertake a Joint Venture between QMG and Blessing Hospital, the local hospital and owner of the existing ASTC, for the new ASTC at 3347 Broadway Street.

3. Build the ASTC at a different site.

4. Construct a traditional cardiac cath lab adjacent to the ASTC at 3347 Broadway, rather than establishing the cardiac catheterization program as a service line within the ASTC.

5. Offer a broader array of clinical services beyond ambulatory surgery and catheterizations at the proposed Broadway location.

1. Modify Existing Lease Arrangement for Existing ASTC at 1118 Hampshire.

QMG owns the building and land on which the existing ASTC in Quincy is located. The building at 1118 Hampshire is on the campus of QMG, and is adjacent to the QMG medical office building at 1025 Maine Street. QMG previously owned the ASTC, but, in order to raise funds in 2006, QMG sold the license to the local hospital, and entered into a lease with the local hospital as tenant to rent the facility from QMG. QMG retains ownership of the land and building. Over 80% of surgeries at the ASTC are performed by QMG physicians. The lease of the ASTC space expires in 2028. QMG has a contract with the local hospital and owner of the existing ASTC to manage the ASTC; however, policies, practice (such as scheduling and staffing), and pricing are solely directed by the owner of the existing ASTC.

Taking over ownership of the ASTC would allow QMG to establish its own policies and set lower prices than the hospital outpatient rates currently charged by the owner of the existing ASTC. QMG would like to take over ownership of the ASTC and made a proposal regarding the same to the owner of the existing ASTC. The owner of the existing ASTC did not respond positively to QMG's request to evaluate changing the existing arrangement. This alternative was rejected because the owner will not consider relinquishing ownership of the ASTC. If the owner were agreeable to the transaction, QMG would file a Certificate of Exemption with the HFSRB to change ownership of the facility.

Internal numbers suggest this alternative would be cost prohibitive. Due to lack of interest by the owner of the existing ASTC, a formal cost proposal was not developed.

2. Undertake Joint Venture for New ASTC and Cardiac Catherization Service at 3347 Broadway Street.

QMG proposed a joint venture arrangement for the proposed ASTC at 3347 Broadway Street to the local hospital and owner of the existing ASTC. The arrangement would allow both organizations to work collaboratively to deliver surgical and cardiac catheterization services to patients of each organization. A surgery center with lower pricing would be more attractive and beneficial financially to area residents (in the form of lower deductibles), and to employers and insurers, due to the lower cost of service.

The proposal was rejected.. As a result, this alternative was rejected.

The cost of the joint venture development at 3347 Broadway would be slightly higher than the proposed project, due to the additional legal cost to establish the joint venture.

3. Build the ASTC at a Different Location.

There is no expansion space available in QMG's current main building at 1025 Maine Street in Quincy. As a result, QMG considered several sites in the Quincy area, identified by its property advisors. These included options to take over and renovate existing space or construct a new building on Quincy's riverfront, as well as an east end building vacated by an electronics retailer. Each of the other locations had several attractive features. For example, the riverfront property provided a spectacular view of the two bridges between Illinois and Missouri, as well as providing an economic boom to an area that is in need of development. The location on east Broadway is right off the interstate and would have made for easy access from all directions.

The location of QMG's main campus is only 1 mile from the Mississippi River. Missouri locations on the west side of the river are available and attractive, and almost as close to the main QMG office building at 1025 Maine Street as is the proposed ASTC location at 3347 Broadway. A number of these sites have convenient access and ample available parking. QMG has several existing office locations in Missouri, so an ambulatory care facility with cardiac catheterization in Missouri is appealing to QMG.

These alternative locations were ultimately rejected because the site at 3347 Broadway has several advantages. The building is appropriately sized to accommodate the clinical program, can accommodate the potential for future expansion (if needed), has ample convenient parking, and has the additional community benefit of avoiding a potentially long term vacancy in the mall where it will be located.

Capital costs associated with these alternatives were estimated to range from $19 to $23 million.

4. Construct Traditional Cardiac Catheterization Lab Adjacent to ASTC.

QMG's original plan was to construct a traditional cardiac catheterization lab adjacent to the ASTC. However, a more cost effective way of delivering cardiac catheterization services is emerging and currently under review by the Centers for Medicare and Medicaid Services (CMS). It is anticipated that final rules will be published in November 2018, proposing to add 12 cardiac catheterization procedures to the ambulatory surgery center covered procedures list for 2019. Such a ruling would enable ASTCs to provide more full service cardiology services, supplementing limited services now performed in ASTCs, such as implanting pacemakers that are prohibited in cardiac catheterization labs. Providing cardiac catheterization services in an outpatient setting is more cost effective than in a hospital outpatient department setting, as hospital outpatient department rates are higher than ambulatory surgical center rates.

The Ambulatory Surgery Center Association has been lobbying to expand the approved list to include cardiac catheterization codes on the covered procedures list. If adopted, the new rules would become effective January 1, 2019. Such a change would allow QMG to provide high quality catheterization services at the new ASTC at a significantly reduced cost, to the benefit of patients, employers, and insurers.

The extra capital cost to build and equip a traditional catheterization lab is estimated at an additional $1,000,000 above the cost of the proposed project.

The option to construct a traditional catheterization lab was not accepted as the preferred option, due to the preference for providing lower cost cardiac catheterization services in an ASTC. If, however, CMS does not broaden the list of covered procedures to include cardiac catherizations, QMG may elect to modify this permit application and introduce a traditional catheterization lab, or postpone the catheterization component of the project. In that case, all 8 rooms would be used for surgical cases and procedures.

5. Offer Broader Array of Clinical Services Beyond Ambulatory Surgery and Catheterizations at the Proposed Broadway Location.

QMG considered other clinical services, such as medical offices, diagnostic imaging, and an immediate care center. These other services are not part of the program of services. QMG's medical offices in the Maine building are cramped but sufficient for current needs, and there are planned retirements in the next five years. QMG has diagnostic imaging equipment in its main office building. An immediate care center is not in the mix of services offered by QMG in the proposed project, since it is available in the main QMG campus.

As a result, such service extensions are not part of the proposed project. There is opportunity for expansion in future years, if need dictates and interest supports.

Additional services would add capital costs in the range of $6 to $12 million.

Having considered these alternatives, QMG elected to pursue the establishment of an outpatient center offering ambulatory surgery with cardiac catheterization and CT scanning at the site at 3347 Broadway in Quincy.

Attachment 14 – Size of Project

The project involves construction in a vacated retail building at 3347 Broadway, Quincy IL. Total square footage of the project is 26,850 sq ft. Of the total 26,850 sq ft, 19,385 sq ft is clinical; 7,465 is non-clinical.

Clinical space includes 5 operating rooms, one of which is dedicated to cardiac catheterization, and 3 procedure rooms, 10 phase I recovery stations, 6 phase II recovery stations, sterile supply, anesthesia and the nursing station, clinical support areas and interior circulation. The project **also includes a CT scanner to relieve capacity on the CT scanner at QMG's main practice office,** 1025 Maine Street, Quincy.

The non-clinical space includes: lobby, reception, and waiting areas; public toilets and family room; lockers and lounges; conference room; medical records; mechanical and building systems, housekeeping; and circulation.

The size of the project is consistent with State standards:

SIZE OF PROJECT				
DEPARTMENT/SERVICE	**PROPOSED DGSF**	**STATE STANDARD**	**DIFFERENCE**	**MET STANDARD?**
Cardiac Catheterization (Occupies one of the 5 ORs)	1,500	1 x 1,800 = 1,800	300 sq. ft.	Yes
Ambulatory Surgery				
Operation rooms (4)	10,240	4 x 2,7500 = 11,000	760 sq. ft	Yes
Procedure rooms (3)	2,410	3 x 1,100 = 3,300	890 sq. ft.	Yes
Phase I recovery (10)	1,450	10 x 180 = 1,800	350 sq. ft.	Yes
Phase II recovery (6)	2,235	6 x 400 = 2,400	165 sq. ft.	Yes
Subtotal surgery	16,335			
CT Scanner	1,550	1 x 1,800 = 1,800	250 sq. ft.	Yes
TOTAL CLINICAL SPACE	19,385			

NOTE:

The 5 ORs, including the OR containing the catheterization service, total 11,740 dgsf. This amount of space compares favorably to the standard for 5 ORs, 13,750 sq ft (= 5 x 2,750 sq ft).

Attachment 15 – Project Services Utilization

The plan for 8 rooms (5 ORs and 3 procedure rooms) is supported by historic and projected surgical cases and procedures, and cardiac catheterizations.

The following table shows the subset of surgical cases conducted by Quincy Medical Group (QMG) physicians in area hospital ORs and ASTCs that qualify as "ASC eligible." These ASC eligible cases are about 15% lower than actual surgical and procedure volumes conducted by QMG physicians, and adjust for co-morbidities (conditions that may dictate that the case be done in a hospital setting), or for insurance policy restrictions, patient preferences, or other factors.

Outpatient Surgical Cases and Procedures – Provided by Quincy Medical Group Physicians

Year	Historic Utilization (Cases)	Projected Utilization (Cases)	State Standard	Met Standard?
2012	9,376	-		
2013	9,886	-		
2014	10,256	-		
2015	11,049	-		
2016	11,321	-		
2017	11,695	-		
2018	11,745	-		
2019	-	11,921		
2020	-	12,100		
2021	-	12,280		
2022	-	12,465		
2023	-	12,654 (10,650 hrs)	1500 hrs/rm	Yes, (7.1 rooms)

Full year case volume for Year 2018 was annualized using 6 months of experience data through June 30. The table shows that surgical cases increased by 25.3 % from 2012 through 2018, an annual average increase of 4.2%. Cases are converted to hours by multiplying number of cases by 0.84 hours, the average surgical/procedure time, including clean up. 0.84 hours is based on Statewide and HSA 3 averages from year 2016 HFSRB inventories.

Annual projections for years 2019 through 2023 are based on an annual average growth rate of 1.5%. This is a conservative growth rate when compared to the historic rate of 4.2% for the years 2012 through 2018. Year 2023 is two years after project completion. The case volume of 12,654 cases, at 0.84 hours, generates 10,650 hours. At 1500 hours per OR or procedure room, the case hours support 7.1 rooms for surgical cases and procedures (8 rooms).

The 8th OR is dedicated to cardiac catheterization. The following table presents historic and projected catheterization volumes as justification for the 8th room at the ASTC.

Cardiac Catheterizations –
Provided by Quincy Medical Group Physicians

Year	Historic Utilization (Cases)	Projected Utilization (Cases)	State Standard	Met Standard?
2012	694	-		
2013	741	-		
2014	912	-		
2015	911	-		
2016	890	-		
2017	794	-		
2018	584	-		
2019	-	593		
2020	-	602		
2021	-	611		
2022	-	620		
2023	--	629 (413 hrs)	200 cases	Yes

The above table shows that the project exceeds the State standard of 200 cardiac cath cases to establish a program. Further documentation of the cath volumes and projections is provided in section 1110.1540 (d) Service Demand, Establishment of an ASTC.

The utilization of the room dedicated to caths can also be demonstrated by analyzing hours of cath activity. The average cath time (with clean up) is about 40 minutes. As a result, the projected 629 procedures generates 413 hours. This volume, when added to the 10,650 hours of surgeries and procedures in the 7 ORs, generates a total of 11,063 hours for the 8 rooms. At 1500 hours per surgical and procedure room, the 11,063 hours require 7.38 rooms, rounded to 8.

The project also includes a CT scanner. The following table presents historic and projected CT scans, as justification for location of a CT scanner at 3347 Broadway Street to supplement the volumes at the existing QMG scanner located at the practice at 1025 Maine Street, Quincy.

CT scans conducted at 1025 Maine Street grew from 4,186 visits in year 2013 to 6,507 in 2018. This 55.4% increase is an average annual increase of 11.1%. A conservative annual increase of 5.0% from 2019 through 2023 will result in a projected volume of 8,305 visits in 2023. This volume supports full utilization of the existing CT scanner and the justification for a second unit.

CT Scan Visits –
Provided by Quincy Medical Group Physicians

Year	Historic Utilization (Visits)	Projected Utilization (Visits)	State Standard	Met Standard?
2013	4,186			
2014	4,259			
2015	5,090			
2016	5,750			
2017	6,420			
2018	6,507			
2019		6,832		
2020		7,174		
2021		7,533		
2022		7,909		
2023		8,305	7,000 visits	Yes

Section 1110.225 - Cardiac Catheterization

Attachment 22

1110.225(a) - Peer Review

The following pages describe the peer review program and process.

Attachment 22

Cardiac Cath Peer Review

The Quincy Medical Group Cardiac Cath Lab would develop a robust peer review process for data registry and peer review. In addition to the ASTC peer review process, the cath lab would have a distinct and separate structure and personnel in place for peer review/quality assurance. For the cardiac portion, we would participate in the NCDR (National Cardiovascular Data Registry) to accomplish these goals and benchmark our performance against other institutions providing cardiac services. The NCDR CATH PCI would be the module most appropriate for our cath lab that may perform diagnostic catheterizations and PCIs (percutaneous interventions). NCDR participation would allow us access to quarterly report which would provide us the ability to see our own standing in the designated capture area. NCDR will provide data on outcome, quality and performance measures including complication rates, and compare to the regional norm and the national norm. We would establish our meetings as monthly peer review sessions, and that committee will develop criteria for case selection.

Many of the quality metrics are centered on appropriate use criteria and delivery of standard of care practice. There are additional incentives and benefits of participating in the NCDR, as many of the payors have specifically asked for the performance in NCDR measures for contracting purposes to assure care quality for their members.

The following are the sample metrics. They are broken down to the following measures and metrics. The cardiac cath lab will have a designated full time cath lab quality officer who gathers and submits these data.

1. PCI performance measures
2. PCI Process metrics
3. Diagnostic cath process/outcomes metrics
4. AUC Metrics (there are 7 metrics under this subset)
5. PCI Outcome Metrics
6. Utilization/data quality Metrics.

The Cath Lab best practices are as follows:

- **Credentialing and certification of cardiac catheterization team.** Physicians working in the lab must maintain proper credentialing, and any other members of the medical staff operating in the lab must have the proper certifications and experience. In addition, procedure outcomes, including success rates and observed complications, should be documented.

- **Pre-procedure checklist for cardiac catheterization.** A pre-procedure checklist should be implemented to guide the attending physician through a list of questions to review and verify prior to initiating the procedure. A common tool used in other medical specialties, the checklist includes affirmation of the procedure type, pre-catheterization assessments, as well

as a review of the patient's health history, ability to adhere to medication regimens, informed consent, sedation, and allergies.

- **Informed consent.** Included within the pre-procedure best practices is the importance of receiving informed consent from the patient, ideally with a third-party witness. The paper points out the importance of verifying the patient fully understands what the procedure entails; the risks, benefits and alternatives to the treatment proposed; as well as potential outcomes and complications that may occur during and after the procedure.

- **Recommended "time out" protocol.** The "time out" should be performed immediately before the procedure and when all members of the medical team are present. During this "time out" period, patient identification should be verified, as well as procedure route, procedure equipment, patient allergies and special medical conditions.

- **Patient preparation in the procedure room.** Best practices during the procedure include a thorough review of the patient's medical record, access site concerns, allergies, blood test results, recent medications, advance directives, informed consent and living wills.

- **Appropriate post-procedure communication and evaluation.** Following the procedure, the patient must be carefully monitored during the hospital stay. The physician should discuss the results of the procedure, as well as complications, unexpected findings and events with the patient and family, as well as with the healthcare providers who will assume care of the patient. The physician should also explain the important role of patient adherence with prescribed medications.

- **Planned follow-up.** Best post-procedure practices include scheduling the patient's follow-up appointment two to four weeks after discharge to confirm the access site is healing, ascertain that there are no medication complications or problems with adherence, evaluate current lifestyle limitations and enroll in cardiac rehabilitation.

- **Quality assurance protocols.** Each cardiac cath lab should have processes in place for nonbiased, education-based peer review of procedures.

- **Transfer agreements**. Transfer agreements and/or policies must be developed with area hospital(s) in order to provide appropriate care for patients in the event of any emergency or other need to transfer a patient.

The various registries that may be needed include:

The Chest Pain - MI Registry Collects:

- STEMI and NSTEMI patient demographics
- Provider and facility characteristics
- Adverse event rates
- AMI performance measures and selected quality measures and outcomes
- All other test measures, including medication dosing errors and risk-adjusted metrics

- Transfer facility therapies and reperfusion strategies
- Compliance with ACC/AHA clinical guideline recommendations
- Data needed to qualify registry performance achievement award recognition

The AFib Ablation Registry Collects:

- Patient demographics for atrial fibrillation ablation procedures
- Procedure prevalence and acute management approaches
- Provider and facility characteristics
- History/risk factors
- Device utilization and adverse event rates
- Data will support the development of evidence-based guidelines for atrial fibrillation treatments

The CathPCI Registry Collects:

- Patient demographics for diagnostic coronary angiography and percutaneous coronary intervention (PCI) procedures
- Patient history/risk factors, cath lab visit indications and coronary lesion information
- Provider and facility characteristics
- PCI Indications, lesion information, intracoronary device utilization and intra/post-procedure events
- 30-day and 1-year follow-up information on patients who had PCI

The ICD Registry Collects:

- Demographics for implantable cardiac defibrillator patients
- Provider and facility characteristics
- Device type and characteristics for ICD implantation
- Atrial, ventricular, defibrillator and left-heart lead data
- Adverse event rates
- Compliance with ACC/AHA/HRS clinical guideline recommendations
- Data necessary for meeting the Centers for Medicare and Medicaid Services requirements for hospitals that perform ICD implantation procedures

The IMPACT Registry Collects:

- Demographics for all pediatric and adult congenital heart disease patients undergoing diagnostic catheterizations and catheter-based interventions
- Provider and facility characteristics
- Data for diagnostic catheterization procedures and six defined interventional procedures
- Adverse events rates
- Data necessary to participate in the American Board of Pediatrics MOC Part IV Credit self-directed performance improvement program Reducing Radiation Risk
- EP ablation

- Transcatheter pulmonary valve replacement

The LAAO Registry Collects:

- Patient demographics for left atrial appendage (LAA) occlusion procedures
- Procedure prevalence and acute management approaches
- Provider and facility characteristics
- History/risk factors
- Adverse event rates
- Data necessary for meeting the Centers for Medicare and Medicaid Services requirements for hospitals that perform percutaneous left atrial appendage closure procedures

1110.225(b) - Establishment or Expansion of Cardiac Catheterization Service

a. The Planning Area for cardiac catheterization services is HSA 3. The map on the following page shows the locations of three hospitals in HSA 3 that provide cardiac catheterization services:

Blessing Hospital, Broadway at 11th Street, Quincy
Memorial Medical Center, 701 N. First Street, Springfield
HSHS **St John's Hospital, 800 East Carpenter Street,** Springfield

b. The number of cardiac catheterizations performed at these three hospitals is as follows, for year 2016, the most recent year reported. Source: HFSRB Hospital Profiles.

Blessing Hospital: 3054 procedures, 3 labs
Memorial Medical Center: 5,856 procedures, 6 labs
HSHS **St John's Hospital: 10,323 procedures, 8 labs**

Each of these three hospitals far exceeds the standard of 400 annual procedures per lab.

c. Quincy Medical Group physicians referred or conducted the following numbers of cardiac catheterizations in each of the past several years:

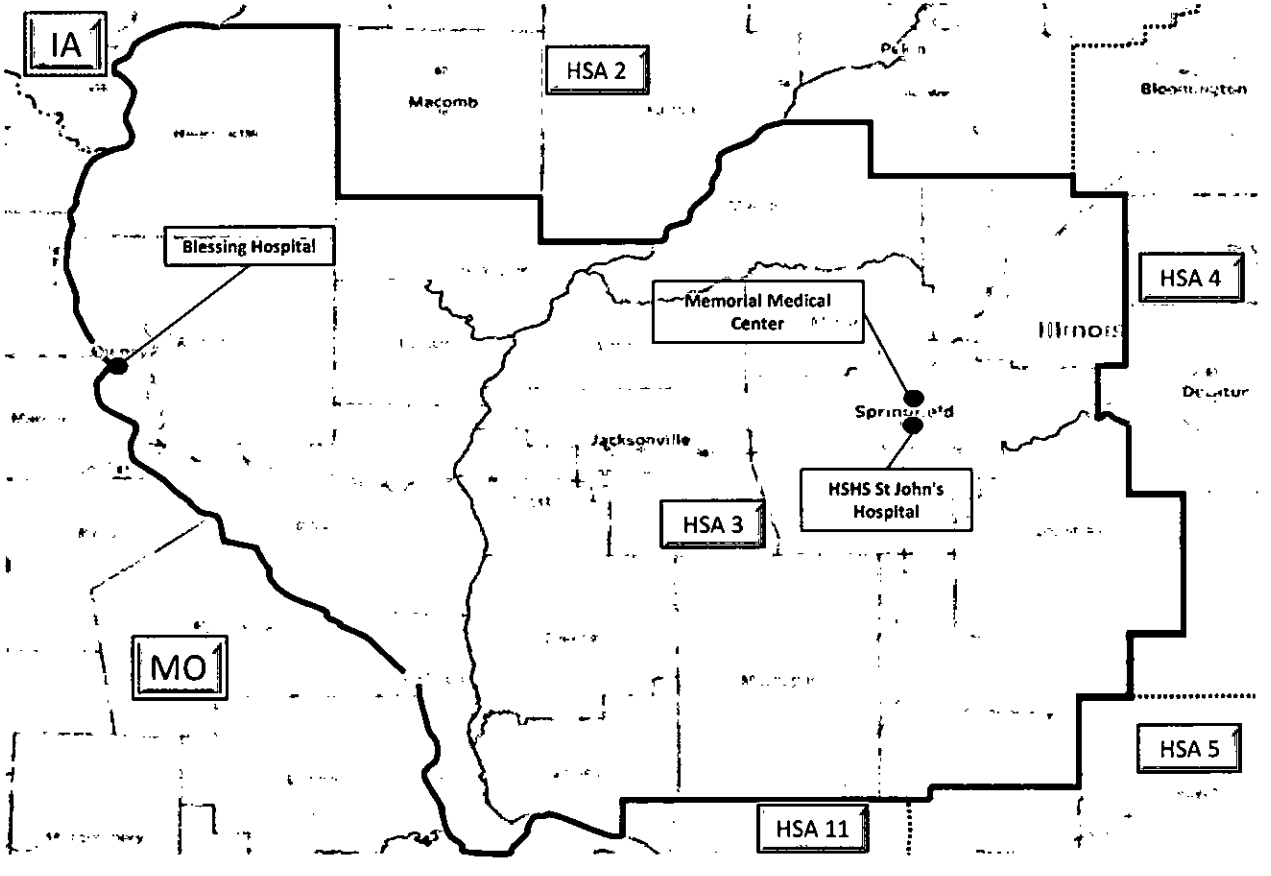
2014: 912
2015: 911
2016: 890
2017: 794

A table of procedures by physician for each of the past three years is included in this section. This information shows that QMG physicians referred and conducted more than 400 cardiac catheterizations each year for the past three years at existing hospitals. QMG is committed to meeting the need for interventional cardiac services, including catheterizations, generated by the members of the physician group. Recruitment of two interventional cardiologists is planned for 2019.

Historic volumes meet the requirement for a minimum of 200 caths per year as the State standard for establishment of a program (1110.620). As presented in the Project Services Utilization Section (Attachment 15), an estimated 629 annual cases are projected for year 2023, 2 years after project completion.

Attachment 22

Location of Hospitals Providing Cath Services in HSA 3



Attachment 22

QUINCY MEDICAL GROUP
QUINCY-QMG CON VOLUME ANALYSIS

QMG HISTORICAL CARDIAC CATHETERIZATION CASE VOLUME BY SPECIALTY CY2015 - CY2017

	2015	2016	2017	
	Blessing Hospital - Outpatient	Blessing Hospital - Outpatient	Blessing Hospital - Outpatient	Hannibal Regional Hospital - Outpatient
Other - Cardiac Catheterization [1,2]				
DERIAN, WISSAM	187	211	181	-
EFSTRATIADIS, STILIANOS	724	679	612	1
Total Case Volume	**911**	**890**	**793**	**1**

[1] Other - Cardiac Catheterization includes only non-surgical CPT codes beginning with 7- or 9-

[2] Historical ASC eligible OP cases were reduced by 15% to control for co-morbidities, insurance denials, patient preference, and other unknown factors that may prevent

Attachment 22

1110.225(c) - Unnecessary Duplication of Services

Quincy Medical Group sent letters to the three facilities in HSA 3 which provide cardiac cath services. Copies of the letters are included following this page. Responses will be forwarded to the State upon receipt by Quincy Medical Group.

The introduction of a catheterization service by QMG, with a projected volume of 629 cases in year 2023, will not reduce the volumes of any of the existing three services below 400 annual caths per lab. As reported in 1110.225(b), the existing facilities are operating at the following levels, according to the State's most recent inventories for year 2016:

Memorial Medical Center, Springfield: 5,856 procedures, 6 labs; 976 procedures per lab
Blessing Hospital, Quincy: 3,054 procedures, 3 labs; 1018 procedures per lab
HSHS St. John's Hospital, Springfield: 10,323 procedures, 8 labs; 1,290 procedures per lab

Even if all of the 629 procedures were to relocate from the local hospital in Quincy, that hospital's volume would remain at over 800 procedures per lab, well above the standard.

As a result, the proposed project does not result in an unnecessary duplication of service.

Attachment 22

QUINCY MEDICAL GROUP

October 23, 2018

Ms. Maureen Kahn, President
Blessing Hospital
Broadway at 11th Street
Quincy, IL 62301

Dear Ms. Kahn:

This letter is to inform you that Quincy Medical Group (QMG) will be submitting a Certificate of Need permit application to establish an Ambulatory Surgery Treatment Center (ASTC). The ASTC will have 5 Operating Rooms and 3 procedure rooms. One of the five ORs will be dedicated to a cardiac catheterization service.

It is required that we notify all providers of surgery service within 21 miles of the proposed site, 3347 Broadway, and providers of cardiac catheterization within Health Service Area 3 for the catheterization service. We are sending this notice to Blessing Hospital, as the provider of surgical and cardiac catheterization services, as required by regulations of the Illinois Health Facilities and Services Review Board.

Please respond with your statement of the impact of the proposed project on Blessing Hospital's surgical and cardiac catheterization services, and on the Blessing Hospital ASTC at 1118 Hampshire Street.

If you have any questions about this project, please contact me.

Sincerely,

Carol Brockmiller

Carol Brockmiller, CMPE
Chief Executive Officer
Quincy Medical Group
1025 Maine Street
Quincy, IL 62301

QUINCY MEDICAL GROUP

October 23, 2018

Dr. Charles Lucore
President and CEO
St. John's Hospital
800 East Carpenter Street
Springfield, IL 62702-3757

Dear Dr. Lucore:

This letter is to inform you that Quincy Medical Group (QMG) will be submitting a Certificate of Need permit application to establish an Ambulatory Surgery Treatment Center (ASTC). The location of the project is 3347 Broadway, Quincy, IL. The ASTC will have 5 Operating Rooms and 3 procedure rooms. One of the five ORs will be dedicated to a cardiac catheterization service.

It is required by regulations of the Illinois Health Facilities and Services Review Board that we notify all providers of cardiac catheterization services within Health Service Area 3. We are sending this notice to you with the request that you provide us with a statement as to the impact you believe our project might have on St John's Hospital's cardiac catheterization service.

If you have any questions about this project, please contact me at 217 222-6550 x 6455.

Thank you for considering this request.

Sincerely,

Carol Brockmiller

Carol Brockmiller, CMPE
Chief Executive Officer
Quincy Medical Group
1025 Maine Street
Quincy, IL 62301

QUINCY MEDICAL GROUP

October 23, 2018

Mr. Edgar J. Curtis
President and CEO
Memorial Medical Center
701 N. First Street
Springfield, IL 62702-5324

Dear Mr. Curtis:

This letter is to inform you that Quincy Medical Group (QMG) will be submitting a Certificate of Need permit application to establish an Ambulatory Surgery Treatment Center (ASTC). The location of the project is 3347 Broadway, Quincy, IL. The ASTC will have 5 Operating Rooms and 3 procedure rooms. One of the five ORs will be dedicated to a cardiac catheterization service.

It is required by regulations of the Illinois Health Facilities and Services Review Board that we notify all providers of cardiac catheterization services within Health Service Area 3. We are sending this notice to you with the request that you provide us with a statement as to the impact you believe our project might have on Memorial Medical Center's cardiac catheterization service.

If you have any questions about this project, please contact me at 217 222-6550 x 6455.

Thank you for considering this request.

Sincerely,

Carol Brockmiller

Carol Brockmiller, CMPE
Chief Executive Officer
Quincy Medical Group
1025 Maine Street
Quincy, IL 62301

1110.225(d) - Modernization of Existing Cardiac Catheterization Laboratories

Not applicable. The project is the establishment of a new service.

Attachment 22

1110.225(e) - Support Services

The following services are available:

- nuclear medicine laboratory
- echocardiography service
- electrocardiography laboratory and services, including stress testing and continuous cardiogram monitoring
- pulmonary function unit
- blood bank
- hematology laboratory – coagulation laboratory
- microbiology laboratory
- blood gas laboratory
- clinical pathology laboratory with facilities for blood chemistry

Quincy Medical Group provides a full complement of ancillary services at its main facility at 1025 Maine Street, Quincy. The pulmonary function department is staffed by respiratory therapists and a board certified pulmonologist. QMG's cardiac services unit includes echocardiography staffed by registered diagnostic cardiac sonographers, a cardiac rehab unit, event monitors and Holter monitors. The nuclear medicine laboratory is adjacent to the cardiac services department; it accommodates stress tests (treadmill and Lexiscan) and multiple gated acquisition scans (MUGA).

QMG's full-service laboratory includes the departments of chemistry, immunochemistry, hematology, microbiology, serology, immunology and urinalysis. Lab services also include ABGs (arterial blood gas). The laboratory director is knowledgeable and educated on the requirements of a laboratory offering transfusions and operating a blood bank. QMG works through the local American Red Cross to dispense packed cells, platelets and FFP (Fresh Frozen Plasma).

Pathology services are sent to and performed by West Central Pathology Specialists.

Attachment 22

1110.225(f) - Laboratory Location

This criterion applies to facilities that have multiple cath labs. The proposed facility has only one cath room, and it will be located within the OR suite. It will be one of the 5 ORs within the proposed ASTC at 3347 Broadway.

Attachment 22

1110.225(g) - Staffing

Quincy Medical Group Cardiac Cath service will be staffed to meet physician, patient, and regulatory requirements. With more than 875 employees, QMG has been the non-hospital employer of choice in the area for health care professionals. The staffing model will assure that QMG provides the same level of quality services that this region has come to expect from Quincy Medical Group in a safe and efficient manner.

A QMG Board Certified Cardiologist will serve as director. There are presently two cardiologists at QMG who perform caths, and recruitment of a cardiology interventionist is underway to replace a physician who left this summer.

QMG currently employees several RNs with ACLS certification and hospital CVU and ICU backgrounds. Some of the nurses at QMG have joined the staff to work with cardiologists whom they know and trust. QMG has not experienced a shortage of RNs seeking employment at QMG. QMG receives about 5 applications for each RN position posted. Currently at QMG there are 12 RN positions open, with 31 applicants vying for those positions and who have made it through initial screening. It has not been necessary to use the services of an outside agency to recruit nurses. HR staff and QMG nursing directors have found that specialty nursing positions have the highest volume of applicants. QMG enjoys a very good retention rate, as a result of very selective hiring practices and proven procedures.

The Quincy region has three colleges offering RN education and one offering a surgical technician program. All three colleges have a web board that their alumni access that lists all employment opportunities. QMG continues to work with all local colleges to provide educational experiences to their students and recruit their new graduates.

The location of the catheterization service within QMG's ASTC enables other surgeons and anesthesiologists to be available for support if needed.

Staffing will be supplemented with new graduates from one of the three area RN programs. Professional staff, such as cardio pulmonology technicians and radiologic technicians, will be recruited. Local professionals seeking change or professionals desiring to move to the Quincy area have always met the needs of QMG expansions and growth; the same is anticipated with this community and regional service line.

Contracts with equipment suppliers and vendors will provide assurances of immediate availability on days and times to address equipment needs.

Attachment 22

1110.225(h) - Continuity of Care

Quincy Medical Group is pursuing the required referral agreement with an area provider of cardiac surgery for the transfer of seriously ill patients. The finalized agreement will be submitted during the review process.

Attachment 22

1110.225(i) – Multi-Institutional Variance

A multi-institutional variance is not needed for the proposed project. Such variances are relevant when the proposed new program is necessary to alleviate excessively high demands on an existing program's operating capacity.

Attachment 22

Section 1110.255 - Non-Hospital Based Ambulatory Surgery

Attachment 24

1110.235(c)(2)(B) Service to GSA Residents

The Geographic Service Area (GSA) consists of zip codes all or part of which are located within a 21 mile radius of the project. The table on the next page shows the 28 zip codes that constitute the GSA. 17 are in Illinois, 11 in Missouri. These zip codes have a population of 91,401. In 2017, 9,208 residents of this area had outpatient surgery or procedures performed by QMG physicians. This constitutes 66% (approximately 2/3) of the total of 13,693 surgical cases performed by QMG physicians in 2017. Because more than 50% of the total annual surgical patients reside in the GSA, it can be documented that the primary purpose of the ASTC project is to provide health care to residents of the GSA.

Attachment 24

Table: ASTC Geographic Service Area (GSA)

Zip Code	Community	Population (2014)	Patients Ref'd by QMG for Outpatient Surgery (2017)	% Of Total Outpatient Surgery Cases From This Zip Code	Cumulative %
Zip Codes (In Whole or In Part) Within 21 Miles of Project Site					
62301	Quincy IL	27620	3619	26.43%	26.43%
62305	Quincy IL	18110	2489	18.18%	44.61%
63401	Hannibal MO	18700	531	3.88%	48.48%
63435	Canton MO	3120	228	1.67%	50.15%
63461	Palmyra MO	5180	234	1.71%	51.86%
62347	Liberty IL	2250	202	1.48%	53.33%
62320	Camp Point IL	1990	232	1.69%	55.03%
62351	Mendon IL	1620	214	1.56%	56.59%
62360	Payson IL	1630	178	1.30%	57.89%
62338	Fowler IL	1400	153	1.12%	59.01%
62376	Ursa IL	1210	149	1.09%	60.10%
63448	La Grange MO	1380	162	1.18%	61.28%
63440	Ewing MO	1200	134	0.98%	62.26%
63454	Maywood MO	870	75	0.55%	62.81%
62349	Loraine IL	580	80	0.58%	63.39%
62343	Hull IL	610	49	0.36%	63.75%
62365	Plainville IL	540	57	0.42%	64.16%
63471	Taylor MO	540	54	0.39%	64.56%
62325	Coatsburg IL	370	49	0.36%	64.92%
63438	Durham MO	380	56	0.41%	65.33%
63463	Philadelphia MO	610	21	0.15%	65.48%
62345	Kinderhook IL	280	35	0.26%	65.73%
62373	Sutter IL	280	22	0.16%	65.89%
63457	Monticello MO	250	15	0.11%	66.00%
62306	Quincy IL	329	17	0.12%	66.13%
62359	Paloma IL	165	22	0.16%	66.29%
62348	Lima IL	102	5	0.04%	66.33%
63467	Saverton MO	85	0	0.00%	66.33%
Subtotal		**91401**	**9082**	**66.33%**	**66.33%**

Zip Code	Community	Population (2014)	Patients Ref'd by QMG for Outpatient Surgery (2017)	% Of Total Outpatient Surgery Cases From This Zip Code	Cumulative %
Zip Codes (In Whole or In Part) Within 22-75 Miles of Project Site					
62363	Pittsfield IL	5110	470	3.43%	69.76%
52632	Keokuk IA	10860	227	1.66%	71.42%
62353	Mt Sterling IL	3190	300	2.19%	73.61%
62312	Barry IL	1790	255	1.86%	75.47%
62681	Rushville IL	4530	119	0.87%	76.34%
62341	Hamilton IL	3150	197	1.44%	77.78%
63445	Kahoka MO	3270	178	1.30%	79.08%
62321	Carthage IL	3590	177	1.29%	80.37%
62340	Griggsville IL	1520	119	0.87%	81.24%
62366	Pleasant Hill IL	1200	117	0.85%	82.09%
63459	New London MO	3740	95	0.69%	82.79%
63456	Monroe City MO	3730	91	0.66%	83.45%
62379	Warsaw IL	1790	122	0.89%	84.34%
63452	Lewistown MO	1000	91	0.66%	85.01%
62324	Clayton IL	1200	113	0.83%	85.83%
63447	La Belle MO	900	69	0.50%	86.34%

62694	Winchester IL	2850	17	0.12%	86.46%
61455	Macomb IL	13050	85	0.62%	87.08%
62339	Golden IL	810	63	0.46%	87.54%
63334	Bowling Green MO	5830	17	0.12%	87.67%
62355	Nebo IL	680	66	0.48%	88.15%
62378	Versailles IL	820	48	0.35%	88.50%
63353	Louisiana MO	4130	57	0.42%	88.91%
62618	Beardstown IL	7680	21	0.15%	89.07%
62314	Baylis IL	530	50	0.37%	89.43%
62356	New Canton IL	410	48	0.35%	89.78%
62311	Augusta IL	750	63	0.46%	90.24%
62354	Nauvoo IL	1300	49	0.36%	90.60%
62316	Bowen IL	580	38	0.28%	90.88%
62367	Plymouth IL	1080	46	0.34%	91.21%
63468	Shelbina MO	2410	24	0.18%	91.39%
62361	Pearl IL	450	16	0.12%	91.51%
62370	Rockport IL	360	38	0.28%	91.78%
62650	Jacksonville IL	20770	10	0.07%	91.86%
62326	Colchester IL	2160	45	0.33%	92.19%
62375	Timewell IL	320	25	0.18%	92.37%
63555	Memphis MO	2820	30	0.22%	92.59%
52639	Montrose IA	1670	6	0.04%	92.63%
63446	Knox City MO	540	27	0.20%	92.83%
63537	Edina MO	1510	46	0.34%	93.16%
52627	Fort Madison IA	10410	20	0.15%	93.31%
63436	Center MO	1050	16	0.12%	93.43%
63462	Perry MO	1310	23	0.17%	93.60%
62362	Perry IL	375	28	0.20%	93.80%
62357	New Salem IL	200	24	0.18%	93.98%
62380	West Point IL	320	32	0.23%	94.21%
63430	Alexandria MO	520	28	0.20%	94.41%
62621	Bluffs IL	1070	11	0.08%	94.49%
62665	Meredosia IL	1230	17	0.12%	94.62%
62330	Dallas City IL	1510	24	0.18%	94.79%
63473	Williamstown MO	260	21	0.15%	94.95%
63469	Shelbyville MO	1060	27	0.20%	95.14%
63441	Frankford MO	990	14	0.10%	95.25%
63382	Vandalia MO	3000	17	0.12%	95.37%
62352	Milton IL	224	13	0.09%	95.46%
62313	Basco IL	340	27	0.20%	95.66%
63472	Wayland MO	380	22	0.16%	95.82%
62323	Chambersburg IL	200	17	0.12%	95.95%
63465	Revere MO	410	16	0.12%	96.06%
61450	La Harpe IL	1510	26	0.19%	96.25%
63474	Wyaconda MO	430	26	0.19%	96.44%
62346	La Prairie IL	210	27	0.20%	96.64%
63434	Bethel MO	570	14	0.10%	96.74%
63453	Luray MO	340	13	0.09%	96.84%
63501	Kirksville MO	14130	9	0.07%	96.90%
63443	Hunnewell MO	320	15	0.11%	97.01%
52625	Donnellson IA	2430	3	0.02%	97.03%
61452	Littleton IL	240	7	0.05%	97.09%
52619	Argyle IA	530	6	0.04%	97.13%
62344	Huntsville IL	145	5	0.04%	97.17%
62319	Camden IL	245	7	0.05%	97.22%
62358	Niota IL	690	7	0.05%	97.27%
61440	Industry IL	660	10	0.07%	97.34%
63336	Clarksville MO	990	3	0.02%	97.36%

61420	Blandinsville IL	960	15	0.11%	97.47%
62639	Frederick IL	260	2	0.01%	97.49%
62334	Elvaston IL	143	13	0.09%	97.58%
63439	Emden MO	179	10	0.07%	97.66%
62624	Browning IL	450	1	0.01%	97.66%
52601	Burlington IA	25990	2	0.01%	97.68%
63339	Curryville MO	930	2	0.01%	97.69%
65283	Stoutsville MO	340	8	0.06%	97.75%
63458	Newark MO	234	4	0.03%	97.78%
62610	Alsey IL	245	6	0.04%	97.82%
61501	Astoria IL	1540	6	0.04%	97.87%
62045	Hamburg IL	420	10	0.07%	97.94%
63432	Arbela MO	420	8	0.06%	98.00%
63563	Rutledge MO	550	4	0.03%	98.03%
62053	Kampsville IL	520	1	0.01%	98.04%
61422	Bushnell IL	2890	17	0.12%	98.16%
63344	Eolia MO	1380	0	0.00%	98.16%
65275	Paris MO	1990	6	0.04%	98.20%
63543	Gorin MO	280	3	0.02%	98.23%
62691	Virginia IL	2100	0	0.00%	98.23%
63552	Macon MO	6910	3	0.02%	98.25%
61484	Vermont IL	720	1	0.01%	98.25%
63460	Novelty MO	240	5	0.04%	98.29%
63359	Middletown MO	1180	0	0.00%	98.29%
62374	Tennessee IL	290	6	0.04%	98.33%
62082	Roodhouse IL	2390	1	0.01%	98.34%
63547	Hurdland MO	360	1	0.01%	98.35%
63531	Baring MO	430	2	0.01%	98.36%
62070	Mozier IL	40	1	0.01%	98.37%
62611	Arenzville IL	930	2	0.01%	98.39%
65265	Mexico MO	13560	0	0.00%	98.39%
61438	Good Hope IL	660	10	0.07%	98.46%
62092	White Hall IL	2310	0	0.00%	98.46%
62668	Murrayville IL	1290	1	0.01%	98.47%
63536	Downing MO	770	1	0.01%	98.47%
62663	Manchester IL	283	0	0.00%	98.47%
61441	Ipava IL	770	4	0.03%	98.50%
63437	Clarence MO	1250	0	0.00%	98.50%
63379	Troy MO	23090	2	0.01%	98.52%
62628	Chapin IL	800	0	0.00%	98.52%
63549	La Plata MO	2210	3	0.02%	98.54%
61454	Lomax IL	630	1	0.01%	98.55%
61542	Lewistown IL	3140	2	0.01%	98.56%
63451	Leonard MO	280	2	0.01%	98.58%
62336	Ferris IL	70	2	0.01%	98.59%
65270	Moberly MO	13330	0	0.00%	98.59%
63343	Elsberry MO	3750	1	0.01%	98.60%
62047	Hardin IL	1390	1	0.01%	98.61%
62016	Carrollton IL	3460	1	0.01%	98.61%
52626	Farmington IA	1030	0	0.00%	98.61%
63377	Silex MO	2110	0	0.00%	98.61%
63546	Greentop MO	1470	5	0.04%	98.65%
61480	Stronghurst IL	1170	1	0.01%	98.66%
61411	Adair IL	300	2	0.01%	98.67%
63352	Laddonia MO	950	4	0.03%	98.70%
63345	Farber MO	310	0	0.00%	98.70%
62695	Woodson IL	451	0	0.00%	98.70%
61482	Table Grove IL	550	5	0.04%	98.74%

61415	Avon IL	1550	0	0.00%	98.74%
63548	Lancaster MO	1130	2	0.01%	98.75%
63561	Queen City MO	1020	0	0.00%	98.75%
63533	Brashear MO	720	1	0.01%	98.76%
52658	Wever IA	960	0	0.00%	98.76%
52656	West Point IA	2100	0	0.00%	98.76%
63541	Glenwood MO	320	1	0.01%	98.77%
62631	Concord IL	300	0	0.00%	98.77%
61469	Oquawka IL	1780	2	0.01%	98.78%
61459	Marietta IL	330	1	0.01%	98.79%
52655	West Burlington IA	3830	0	0.00%	98.79%
65240	Centralia MO	7050	0	0.00%	98.79%
63466	Saint Patrick MO	0	0	0.00%	98.79%
63330	Annada MO	140	0	0.00%	98.79%
61470	Prairie City IL	450	0	0.00%	98.79%
61416	Bardolph IL	254	5	0.04%	98.82%
63450	Lentner MO	140	1	0.01%	98.83%
63362	Moscow Mills MO	6160	0	0.00%	98.83%
62673	Oakford IL	460	0	0.00%	98.83%
62651	Jacksonville IL	416	1	0.01%	98.84%
62627	Chandlerville IL	840	0	0.00%	98.84%
61475	Sciota IL	220	3	0.02%	98.86%
52631	Houghton IA	145	0	0.00%	98.86%
63389	Winfield MO	5940	0	0.00%	98.86%
62612	Ashland IL	1790	0	0.00%	98.86%
62050	Hillview IL	360	0	0.00%	98.86%
61473	Roseville IL	1390	0	0.00%	98.86%
52630	Hillsboro IA	340	1	0.01%	98.87%
52623	Danville IA	1960	0	0.00%	98.87%
65243	Clark MO	2600	0	0.00%	98.87%
63559	Novinger MO	1150	0	0.00%	98.87%
63557	New Boston MO	210	0	0.00%	98.87%
63534	Callao MO	660	0	0.00%	98.87%
63433	Ashburn MO	65	0	0.00%	98.87%
62617	Bath IL	590	1	0.01%	98.88%
62006	Batchtown IL	550	0	0.00%	98.88%
61477	Smithfield IL	530	0	0.00%	98.88%
61437	Gladstone IL	700	3	0.02%	98.90%
61427	Cuba IL	2010	1	0.01%	98.90%
52565	Keosauqua IA	1670	0	0.00%	98.90%
52542	Cantril IA	350	0	0.00%	98.90%
65285	Thompson MO	600	0	0.00%	98.90%
65282	Santa Fe MO	115	0	0.00%	98.90%
65262	Kingdom City MO	770	0	0.00%	98.90%
65258	Holliday MO	420	0	0.00%	98.90%
63540	Gibbs MO	142	0	0.00%	98.90%
63532	Bevier MO	1130	0	0.00%	98.90%
63530	Atlanta MO	790	0	0.00%	98.90%
63431	Anabel MO	290	0	0.00%	98.90%
63347	Foley MO	2500	0	0.00%	98.90%
62027	Eldred IL	410	0	0.00%	98.90%
61425	Carman IL	400	0	0.00%	98.90%
52649	Salem IA	840	0	0.00%	98.90%
52645	New London IA	2850	0	0.00%	98.90%
52573	Mount Sterling IA	178	0	0.00%	98.90%
65284	Sturgeon MO	2030	0	0.00%	98.90%
65280	Rush Hill MO	232	0	0.00%	98.90%
65263	Madison MO	1610	0	0.00%	98.90%

65259	Huntsville MO	2480	0	0.00%	98.90%
65255	Hallsville MO	3970	0	0.00%	98.90%
65239	Cairo MO	1250	0	0.00%	98.90%
63567	Worthington MO	123	0	0.00%	98.90%
63539	Ethel MO	186	0	0.00%	98.90%
63387	Whiteside MO	118	0	0.00%	98.90%
63384	Wellsville MO	1430	0	0.00%	98.90%
63361	Montgomery City MO	3820	0	0.00%	98.90%
63349	Hawk Point MO	1700	0	0.00%	98.90%
62660	Literberry IL	51	0	0.00%	98.90%
62078	Patterson IL	86	0	0.00%	98.90%
62065	Michael IL	86	0	0.00%	98.90%
62031	Fieldon IL	890	0	0.00%	98.90%
61471	Raritan IL	128	0	0.00%	98.90%
61447	Kirkwood IL	870	0	0.00%	98.90%
61418	Biggsville IL	610	0	0.00%	98.90%
52624	Denmark IA	375	0	0.00%	98.90%
52620	Bonaparte IA	800	0	0.00%	98.90%
52551	Douds IA	570	0	0.00%	98.90%
Subtotal		**397104**	**4461**	**32.58%**	**98.90%**

Zip Code	Community	Population (2014)	Patients Ref'd by QMG for Outpatient Surgery (2017)	% Of Total Outpatient Surgery Cases From This Zip Code	Cumulative %
Zip Codes (in Whole or in Part) Outside 75 Miles of Project Site					
	Zip Codes Outside Service Area		150	1.10%	100.00%
Grand Total		**488505**	**13693**		

1110.235(c)(3) Service Demand – Establishment of an ASTC

B) Projected Service Demand

The table on the next page records historical outpatient surgical cases that have been conducted by QMG physicians and which would be appropriate for treatment at the proposed ASTC. The increase from 9,376 cases in 2012 to 11,745 cases in 2018 is an annual average increase of 4.2%. A forecasted conservative annual increase of 1.5% from 2018 through 2023 (two years after project completion) results in 12,654 surgical cases in 2023. Using Statewide and HSA 3 average hours per case by specialty results in an estimated forecast of 10,650 hours in year 2023.

The next page provides the letter by the Chief Executive Officer of QMG attesting to the total number of patients who have had surgeries by QMG physicians during 2017, and the collective commitment to refer to the proposed ASTC. The commitment of 10,712 surgical cases is less than the historic 2017 volume of 13,963 outpatient surgeries documented in the patient origin table, and also less than the volumes shown in the above table for ASC eligible cases: 11,321 in year 2016 and 11,695 in 2017.

The commitment of 10,712 surgical cases, a historical number, supports the projection of 12,654 cases for year 2023. The increase from 10,712 cases committed in 2018 to 12,654 cases in 2023 is a 3.6% annual average increase, which is less than the historic growth rate of 4.2% per year.

The growth from 11,745 cases (year 2018) to 12,654 is a conservative annual average growth rate of 1.5%, less than the historical 4.2% growth rate from 2012 to 2018.

The projected patient volume meets the requirement that the project serves residents of the GSA. As shown in the patient origin table, 66% of surgical outpatient cases by QMG physicians reside in the 17 zip codes in the GSA, exceeding the requirement that at least 50% of patients are from the GSA. Patient origin is relatively constant and does not change from year to year.

Attachment 24

QUINCY MEDICAL GROUP
QUINCY-QMG CON VOLUME ANALYSIS

HISTORICAL ASC ELIGIBLE CASE VOLUME BY SPECIALTY AND PHYSICIAN CY2016 - CY2017

		Historic Volume [1]										
		2016				2017						
ASC Surgical Type	# of Committed Referrals [3]	Blessing Hospital - Outpatient	Carthage Memorial Hospital - Outpatient	Illini Hospital - Outpatient	Total 2016 Case Volume	Blessing Hospital - Outpatient	Keokuk Area Hospital - Outpatient	Illini Hospital - Outpatient	Carthage Memorial Hospital - Outpatient	Westlake Community Hospital - Outpatient	Hannibal Regional Hospital - Outpatient	Total 2017 Case Volume
Cardiovascular [4]												
DERIAN, WISSAM	40	46	-	-	46	41	-	-	-	-	-	41
EFSTRATIADIS, STILIANOS	-	80	-	-	80	66	-	-	-	-	-	66
SETHI, GULSHAN	17	-	-	-	-	20	-	-	-	-	-	20
Gastroenterology												
BARBAGIOVANNI, JOHN T	1,628	1,882	-	33	1,915	1,718	-	-	-	-	-	1,718
BOZDECH, JOHN	1,780	2,094	-	-	2,094	1,684	-	-	-	-	-	1,684
PASTORINI, CRISTHINE S	668	236	-	-	236	785	-	-	-	-	-	785
General Surgery												
NYACHOWE, PASCAL N	23	27	-	-	27	-	-	-	-	-	-	-
PETTY, TODD	357	395	-	20	415	394	-	26	-	-	-	420
SMITH, TIMOTHY S	450	529	-	-	529	521	-	-	-	-	-	521
ZWICK, CHRISTIAN R	362	425	-	-	425	387	-	-	-	-	-	387
Neurological Surgery												
GOLD, MARK A	85	88	-	-	88	99	-	-	-	-	-	99
MORRIS, REUBEN	29	19	-	-	19	33	-	-	-	-	-	33
REYNOLDS, ARDEN	80	89	-	-	89	94	-	-	-	-	-	94
Obstetrics/Gynecology												
ALEXANDRE, JEAN C	126	148	-	-	148	145	-	-	-	1	-	146
DURESKA, PETER	49	57	-	-	57	50	-	-	-	-	-	50
KAGUMBA, ADA	30	7	-	-	7	35	-	-	-	-	-	35
MADUAKOR, OBIOMA N	52	61	-	-	61	47	-	-	-	-	-	47
MERO, TANYA	74	87	-	-	87	81	-	-	-	-	-	81
WOODARD, DEBORAH	24	28	-	-	28	27	-	-	-	-	-	27
Ophthalmology												
DISSELER, JEAN A	406	435	-	-	435	477	-	-	-	-	-	477
GEISENDORFER, ABRAM R	624	663	-	-	663	733	-	-	-	-	-	733
PHILLIPS, DAVID L	68	-	-	-	-	79	-	-	-	-	-	79
SIECK, ERIC	646	759	-	-	759	751	-	-	-	-	-	751
WELLER, ROBERT	475	555	-	-	555	558	-	-	-	-	-	558
Oral/Maxillofacial Surgery												
RIGGS, DANIEL E	-	-	-	-	-	-	-	-	-	-	-	-
Orthopedic Surgery												
BINGHAM, DAVID M	153	179	-	-	179	23	-	-	-	-	-	23
CRICKARD, GEORGE	262	243	-	-	243	308	-	-	-	-	-	308
DERHAKE, ADAM D	296	317	-	-	317	348	-	-	-	-	-	348
DUPUIS, CHRISTOPHER	25	-	-	-	-	-	29	-	-	-	-	29

Attachment 24

QUINCY MEDICAL GROUP
QUINCY-QMG CON VOLUME ANALYSIS

HISTORICAL ASC ELIGIBLE CASE VOLUME BY SPECIALTY AND PHYSICIAN CY2016 - CY2017

		Historic Volume [1]										
		2016				2017						
ASC Surgical Type	# of Committed Referrals [5]	Blessing Hospital - Outpatient	Carthage Memorial Hospital - Outpatient	Illini Hospital - Outpatient	Total 2016 Case Volume	Blessing Hospital - Outpatient	Keokuk Area Hospital - Outpatient	Illini Hospital - Outpatient	Carthage Memorial Hospital - Outpatient	Westlake Community Hospital - Outpatient	Hannibal Regional Hospital - Outpatient	Total 2017 Case Volume
MORTON, STEVEN D	3	3	-	-	3	-	-	-	-	-	-	-
TALLERICO, BRIAN D	24	-	-	-	-	28	-	-	-	-	-	28
Otolaryngology												
MARCHIANDO, ALBERT	122	143	-	-	143	137	-	-	-	-	-	137
RUTH, HARRY R	216	240	-	-	240	253	-	-	-	-	-	253
Plastic Surgery												
FYNN-THOMPSON, ERIC K	396	381	-	-	381	465	-	-	-	-	-	465
Podiatric Surgery												
FREEL, DOUGLAS	67	56	14	8	78	41	-	-	8	-	-	49
PATEL, SHWETAL B	165	185	-	-	185	194	-	-	-	-	-	194
Urology												
DOOLEY, RANDALL E	250	251	-	-	251	294	-	-	-	-	-	294
OUWENGA, MICHAEL K	289	339	-	1	340	322	-	-	-	-	-	322
SCHNEIDER, DANIEL E	276	113	-	-	113	324	-	-	-	-	-	324
Other - Pulmonology												
CHBEIR, ELIE A	59	67	-	-	67	69	-	-	-	-	-	69
NASSERY, MANOOCHER	16	18	-	-	18	-	-	-	-	-	-	-
Subtotal ASC Volume	**10,712**	**11,245**	**14**	**62**	**11,321**	**11,631**	**29**	**26**	**8**	**1**	**-**	**11,695**
Other - Cardiac Catheterization [2,3,4]												
DERIAN, WISSAM	154	211	-	-	211	181	-	-	-	-	-	181
EFSTRATIADIS, STILIANOS	-	679	-	-	679	612	-	-	-	-	1	613
KIM, FRANK S	-	-	-	-	-	-	-	-	-	-	-	-
Total ASC + Cardiac Catheterization Volume	**10,866**	**12,135**	**14**	**62**	**12,211**	**12,424**	**29**	**26**	**8**	**1**	**1**	**12,489**

[1] ASC-eligible case volume was derived based upon cases that are approved on the ASC Medicare approved list and adjusted by 15% to control for co-morbidities and other variables that may prevent the case from being done in the ASC.

[2] Other - Cardiac Catheterization case volume includes only non-surgical CPT codes beginning with 7- or 9-.

[3] Other - Cardiac Catheterization physicians Dr. Derian and Dr. Efstratiadis also do cases in the ASC and as a result appear twice in this table.

[4] Dr. Efstratiadis departed QMG in June 2018. Committed Referrals excludes his volume.

[5] Case volume does not include physicians who began doing cases in 2018 or physicians expected to replace retiring physicians.

Attachment 24

QUINCY MEDICAL GROUP
QUINCY-QMG CON VOLUME ANALYSIS

QMG HISTORICAL AND PROJECTED ASC CASE VOLUME BY SPECIALTY FOR ALL LOCATIONS CY2012 - CY2023[1]

	Historic (cases) - All Locations OP Only[2,3]							Projected (cases)[4]					proj'd hrs[5]	
ASC Surgical Type[6,7,9]	2012	2013	2014	2015	2016	2017	2018[8,10]	2019	2020	2021	2022	2023	2023	Hrs/Case[5]
Cardiovascular	-	-	30	106	126	127	181	184	187	190	193	196	129	0.66
Gastroenterology	3,516	3,660	3,770	4,237	4,245	4,187	4,114	4,176	4,239	4,303	4,368	4,434	2,684	0.61
General Surgery	1,377	1,264	1,361	1,349	1,396	1,328	1,250	1,269	1,288	1,307	1,327	1,347	1,658	1.23
Neurological Surgery	25	31	53	104	196	226	264	268	272	276	280	284	421	1.48
Obstetrics/Gynecology	270	257	271	411	388	386	416	422	428	434	441	448	524	1.17
Ophthalmology	1,982	2,408	2,400	2,524	2,412	2,598	2,666	2,706	2,747	2,788	2,830	2,872	1,478	0.51
Oral/Maxillofacial Surgery	-	-	-	-	-	-	8	8	8	8	8	8	12	1.53
Orthopedic Surgery	656	634	633	822	742	736	852	865	878	891	904	918	1,362	1.48
Otolaryngology	459	456	372	339	383	390	196	199	202	205	208	211	224	1.06
Plastic Surgery	482	614	618	187	381	465	432	438	445	452	459	466	630	1.35
Podiatric Surgery	129	140	171	228	263	243	290	294	298	302	307	312	428	1.37
Urology	480	422	556	675	704	940	980	995	1,010	1,025	1,040	1,056	980	0.93
Other - Pulmonology	-	-	21	67	85	69	96	97	98	99	100	102	120	1.18
Subtotal ASC Surgical Type	**9,376**	**9,886**	**10,256**	**11,049**	**11,321**	**11,695**	**11,745**	**11,921**	**12,100**	**12,280**	**12,465**	**12,654**	**10,650**	**0.84**
Other - Cardiac Catheterization	694	741	912	911	890	794	584	593	602	611	620	629	413	0.66
Total ASC + Cardiac Catheterization Volume	**10,070**	**10,627**	**11,168**	**11,960**	**12,211**	**12,489**	**12,329**	**12,514**	**12,702**	**12,891**	**13,085**	**13,283**	**11,063**	**0.83**

[1] ASC-eligible case volume was derived based upon cases that are approved on the ASC Medicare approved list and case typically paid by commercial payors.

[2] Inpatient/Outptient designation was not available for 2012-2014 historical case volume; Outpatient volume for these years was estimated using 2018 experience data.

[3] Historical ASC eligible OP cases were reduced by 15% to control for co-morbidities, insurance denials, patient preference, and other unknown factors that may prevent the case from being done in the ASC.

[4] Projected case volume assumes an increase of 1.5% per year.

[5] Projected hours were based on Statewide and HSA 3 information on ASTC's provided by the State HFSRB website; Times include surgery time, prep and clean up.

[6] Physicians specializing in Neurology or Trauma/Critical Care Surgery were excluded from ASC-eligible volumes.

[7] Other - Pulmology refers to cases being performed by Dr. Elie Chbeir.

[8] Full year surgical case volume for 2018 was annualized using 6 months of experience data from 1/1/18 through 6/30/18.

[9] Other - Cardiac Catheterization volume includes only non-surgical CPT codes beginning with 7- or 9-.

[10] The decrease in Other - Cardiac Catheterization volume in 2018 reflects Dr. Efstratiadis's departure in June 2018. QMG expects half of his volume to be replaced by new physicians going forward.

Attachment 24

QUINCY MEDICAL GROUP

October 12, 2018

Ms. Courtney Avery
Administrator
Illinois Health Facilities and Services Review Board
525 W. Jefferson Street - 2nd Floor
Springfield, IL 62761

Dear Ms. Avery:

This letter conveys the commitment of Quincy Medical Group physicians to refer cases and conduct surgery at the proposed ambulatory surgical treatment center (ASTC) at 3347 Broadway, Quincy.

Collectively, the committed referrals by these 39 physicians totals 10,712. As required, these commitments to refer do not exceed the 13,963 outpatient surgical cases and procedures performed by QMG physicians in year 2017, or the historic referrals of "ASTC eligible" cases of 11,321 in 2016 and 11,695 in 2017. These cases are documented on the attached table, showing case volumes by physician for each year 2016 and 2017, and location of surgical cases and procedures conducted in those years.

These referral counts have not been used to support another permit application for any other hospital or licensed ASTC. The information in this letter is true and correct to the best of my knowledge.

Sincerely,

Carol Brockmiller

Carol Brockmiller, CMPE
Chief Executive Officer
1025 Maine Street
Quincy, IL 62301

Subscribed and sworn to before me this 17th day of October, 2018.

Joann Eversden
Signature of Notary Public

"OFFICIAL SEAL"
JOANN EVERSDEN
Notary Public, State of Illinois
My Commission Expires 09/27/21

QUINCY MEDICAL GROUP
QUINCY-QMG CON VOLUME ANALYSIS

HISTORICAL ASC ELIGIBLE CASE VOLUME BY SPECIALTY AND PHYSICIAN CY2016 - CY2017

		Historic Volume [1]										
		2016				2017						
ASC Surgical Type	# of Committed Referrals [3]	Blessing Hospital - Outpatient	Carthage Memorial Hospital - Outpatient	Illini Hospital - Outpatient	Total 2016 Case Volume	Blessing Hospital - Outpatient	Keokuk Area Hospital - Outpatient	Illini Hospital - Outpatient	Carthage Memorial Hospital - Outpatient	Westlake Community Hospital - Outpatient	Hannibal Regional Hospital - Outpatient	Total 2017 Case Volume
Cardiovascular [4]												
DERIAN, WISSAM	40	46	-	-	46	41	-	-	-	-	-	41
EFSTRATIADIS, STILIANOS	-	80	-	-	80	66	-	-	-	-	-	66
SETHI, GULSHAN	17	-	-	-	-	20	-	-	-	-	-	20
Gastroenterology												
BARBAGIOVANNI, JOHN T	1,628	1,882	-	33	1,915	1,718	-	-	-	-	-	1,718
BOZDECH, JOHN	1,780	2,094	-	-	2,094	1,684	-	-	-	-	-	1,684
PASTORINI, CRISTHINE S	668	236	-	-	236	785	-	-	-	-	-	785
General Surgery												
NYACHOWE, PASCAL N	23	27	-	-	27	-	-	-	-	-	-	-
PETTY, TODD	357	395	-	20	415	394	-	26	-	-	-	420
SMITH, TIMOTHY S	450	529	-	-	529	521	-	-	-	-	-	521
ZWICK, CHRISTIAN R	362	425	-	-	425	387	-	-	-	-	-	387
Neurological Surgery												
GOLD, MARK A	85	88	-	-	88	99	-	-	-	-	-	99
MORRIS, REUBEN	29	19	-	-	19	33	-	-	-	-	-	33
REYNOLDS, ARDEN	80	89	-	-	89	94	-	-	-	-	-	94
Obstetrics/Gynecology												
ALEXANDRE, JEAN C	126	148	-	-	148	145	-	-	-	1	-	146
DURESKA, PETER	49	57	-	-	57	50	-	-	-	-	-	50
KAGUMBA, ADA	30	7	-	-	7	35	-	-	-	-	-	35
MADUAKOR, OBIOMA N	52	61	-	-	61	47	-	-	-	-	-	47
MERO, TANYA	74	87	-	-	87	81	-	-	-	-	-	81
WOODARD, DEBORAH	24	28	-	-	28	27	-	-	-	-	-	27
Ophthalmology												
DISSELER, JEAN A	406	435	-	-	435	477	-	-	-	-	-	477
GEISENDORFER, ABRAM R	624	663	-	-	663	733	-	-	-	-	-	733
PHILLIPS, DAVID L	68	-	-	-	-	79	-	-	-	-	-	79
SIECK, ERIC	646	759	-	-	759	751	-	-	-	-	-	751
WELLER, ROBERT	475	555	-	-	555	558	-	-	-	-	-	558
Oral/Maxillofacial Surgery												
RIGGS, DANIEL E	-	-	-	-	-	-	-	-	-	-	-	-
Orthopedic Surgery												
BINGHAM, DAVID M	153	179	-	-	179	23	-	-	-	-	-	23
CRICKARD, GEORGE	262	243	-	-	243	308	-	-	-	-	-	308
DERHAKE, ADAM D	296	317	-	-	317	348	-	-	-	-	-	348
DUPUIS, CHRISTOPHER	25	-	-	-	-	-	29	-	-	-	-	29

Attachment 24

QUINCY MEDICAL GROUP
QUINCY-QMG CON VOLUME ANALYSIS

HISTORICAL ASC ELIGIBLE CASE VOLUME BY SPECIALTY AND PHYSICIAN CY2016 - CY2017

		Historic Volume [1]										
		2016				2017						
ASC Surgical Type	# of Committed Referrals [5]	Blessing Hospital - Outpatient	Carthage Memorial Hospital - Outpatient	Illini Hospital - Outpatient	Total 2016 Case Volume	Blessing Hospital - Outpatient	Keokuk Area Hospital - Outpatient	Illini Hospital - Outpatient	Carthage Memorial Hospital - Outpatient	Westlake Community Hospital - Outpatient	Hannibal Regional Hospital - Outpatient	Total 2017 Case Volume
MORTON, STEVEN D	3	3	-	-	3	-	-	-	-	-	-	-
TALLERICO, BRIAN D	24	-	-	-	-	28	-	-	-	-	-	28
Otolaryngology												
MARCHIANDO, ALBERT	122	143	-	-	143	137	-	-	-	-	-	137
RUTH, HARRY R	216	240	-	-	240	253	-	-	-	-	-	253
Plastic Surgery												
FYNN-THOMPSON, ERIC K	396	381	-	-	381	465	-	-	-	-	-	465
Podiatric Surgery												
FREEL, DOUGLAS	67	56	14	8	78	41	-	-	8	-	-	49
PATEL, SHWETAL B	165	185	-	-	185	194	-	-	-	-	-	194
Urology												
DOOLEY, RANDALL E	250	251	-	-	251	294	-	-	-	-	-	294
OUWENGA, MICHAEL K	289	339	-	1	340	322	-	-	-	-	-	322
SCHNEIDER, DANIEL E	276	113	-	-	113	324	-	-	-	-	-	324
Other - Pulmonology												
CHBEIR, ELIE A	59	67	-	-	67	69	-	-	-	-	-	69
NASSERY, MANOOCHER	16	18	-	-	18	-	-	-	-	-	-	-
Subtotal ASC Volume	**10,712**	**11,245**	**14**	**62**	**11,321**	**11,631**	**29**	**26**	**8**	**1**	**-**	**11,695**
Other - Cardiac Catheterization [2,3,4]												
DERIAN, WISSAM	154	211	-	-	211	181	-	-	-	-	-	181
EFSTRATIADIS, STILIANOS	-	679	-	-	679	612	-	-	-	-	1	613
KIM, FRANK S	-	-	-	-	-	-	-	-	-	-	-	-
Total ASC + Cardiac Catheterization Volume	**10,866**	**12,135**	**14**	**62**	**12,211**	**12,424**	**29**	**26**	**8**	**1**	**1**	**12,489**

[1] ASC-eligible case volume was derived based upon cases that are approved on the ASC Medicare approved list and adjusted by 15% to control for co-morbidities and other variables that may prevent the case from being done in the ASC.

[2] Other - Cardiac Catheterization case volume includes only non-surgical CPT codes beginning with 7- or 9-.

[3] Other - Cardiac Catheterization physicians Dr. Derian and Dr. Efstratiadis also do cases in the ASC and as a result appear twice in this table.

[4] Dr. Efstratiadis departed QMG in June 2018. Committed Referrals excludes his volume.

[5] Case volume does not include physicians who began doing cases in 2018 or physicians expected to replace retiring physicians.

Attachment 24

1110.235(c)(5) - Treatment Room Need Assessment

The project includes 8 rooms: 5 ORs, one of which is planned to accommodate a cardiac catheterization service, and 3 procedure rooms.

As reported in the Project Services Utilization Section, Attachment 15, the projected volume of 12,654 cases in year 2023 generates 10,650 hours, based on an average case time of 0.84 hours per case. The table on the following page indicates the hours by type of surgical service that will be provided at the ASTC. State and HSA 3 experienced hours by case were used to estimate hours by service.

These 10,650 hours constitute the projected workload in the 7 rooms (4 ORs and 3 procedure rooms). The workloads are not allocated between ORs and procedure rooms at this stage. The standard of 1500 hours per room per year applies to both ORs and procedure rooms. 10,650 hours divided by 1500 hours per room per year yields 7.1 rooms, rounded to 8.

The 5th OR, used for cardiac catheterization, is projected to accommodate 629 cases in year 2023. At 40 minutes per case, these cases will generate 413 hours in year 2023. This volume, when added to the 10,650 hours of surgeries and procedures in the 7 ORs, generates a total of 11,063 hours. At 1500 hours per surgical and procedure room, these 11,063 hours require 7.38 rooms, rounded to 8.

The CT scanner is planned to supplement the growing volume of cases on the CT scanner in operation at 1025 Maine Street, Quincy. As presented in the Project Services Utilization section, a projected volume of 8,305 visits is forecast in 2023. This conservatively projected utilization is above the 7,000 visits State standard for a CT scanner and justifies the unit planned at 3347 Broadway Street.

Attachment 24

1110.235(c)(6) - Service Accessibility

The proposed project will benefit the area population by enhancing access to outpatient surgical services and by offering these services at reduced costs.

Comparing local conditions against standard measures of access does not reveal accessibility problems. There is one other IDPH-licensed ASTC in the identified GSA, the hospital-owned ASTC at 1118 Hampshire, in a building owned by Quincy Medical Group (QMG). That ASTC appears not to be utilized at or above utilization standards, and by that measure, there is available facility capacity. The surgical services to be offered at the proposed ASTC are available at the current hospital-owned ASTC. And the proposed project is not a joint venture or other cooperative venture between the hospital and QMG.

In spite of QMG having a contract with the hospital-owned ASTC to manage the existing ASTC, policies and procedures are dictated by the hospital, not QMG. The hospital hires and employs the staff at the ASTC. The hospital sets the prices, at hospital outpatient department rates, which exceed rates at freestanding non-hospital based ASTCs. The hospital controls the schedule for surgical cases, and contracts with the anesthesia practice at the ASTC.

The effect of these practices limits accessibility to surgical services. For example, the anesthesiology group retained by the hospital at the ASTC usually does not enable surgical cases starting after 3:00 pm. While there may be reasons for this practice, possibly to control operating costs, it does not enable QMG physicians to conduct late afternoon and evening cases that are often preferred by patients, due to work schedules and/or family obligations. Additionally, the hospital's scheduling practices are inefficient, often resulting in surgeons waiting to perform procedures and resulting in wasted time.

QMG is restricted from being able to offer cost competitive surgical services to area employers and insurance companies, because QMG does not control the facility setting. The current hospital-owned ASTC charges HOPD facility rates that are more than 30% higher than rates at ambulatory surgical centers that are not hospital affiliated. The State regulations acknowledge that a cooperative venture with a hospital to establish an ASTC is beneficial when "the proposed charges for comparable procedures at the ASTC will be lower than those at the existing hospital." (1110.235(c)(6)(D)(iv)). In the case of the proposed ASTC, a cooperative venture has been proposed and rejected by the hospital. The ability of QMG to offer services at significantly lower rates is blocked because a cooperative venture with QMG was rejected.

For these reasons, QMG believes that service accessibility can be enhanced and lower costs can be achieved by implementing the proposed ASTC project under its control.

Attachment 24

1110.235(c)(7) - Unnecessary Duplication/Maldistribution

A) The Geographic Service Area (GSA) is defined by a radius of 21 miles from the proposed site at 3347 Broadway. As documented in the section on Service to GSA Residents, the population of the 28 zip codes that lie in whole or in part within the 21 mile radius area is 91,401 (GSA population).

There is one ASTC located within the GSA: the hospital-owned ASTC at 1118 Hampshire, in a building owned by QMG. The facility has 3 operating rooms and 4 procedure rooms (ASTC profiles, year 2016, HFSRB web-site).

B) The project will not result in the maldistribution of services.

The ratio of the number of existing ORs and procedure rooms per thousand population in the GSA already exceeds 1.5 times the State average. This ratio is not the result of the proposed project, but of the existing condition. In part, the ratio reflects the relatively small population of the GSA, more so than the complement of OR and procedure rooms at the hospital-owned ASTC.

The new distance standard (mileage) for defining GSA, instead of the previously used 45 minute travel time, results in a smaller GSA than had been the case in the past. QMG believes that there is relevant information that makes the case that the proposed project does not result in a maldistribution of surgical and procedure rooms:

1. Service area extends far beyond the GSA.

Section 1110.235(c)(7)(B)(iii) states that maldistribution exists when there is "insufficient population to provide the volume or caseload necessary to utilize the surgical/treatment rooms **proposed by the project at or above the utilization standards ..."** The complete service area covered by QMG is relevant to this issue.

As shown in the patient origin table used to define the GSA, 66% of QMG outpatient surgical cases come from the GSA defined by zip codes in whole or in part within the 21 mile radius. This meets the requirement that 50% or more of the projected caseload at the proposed project comes from the GSA.

Further analysis shows that 45% of cases come from the 2 Quincy zip codes. 26 other zip codes combine with these two Quincy zip codes to define the GSA. (28 zip codes are in whole or in part are located within the 21 mile radius of the project site.) The patient origin data indicate both 1) the concentration of cases in the Quincy area, and also 2) the vast extent of the large rural area also served. 167 zip codes contribute the remaining 55% of cases. Other than the two Quincy zip codes, only three other zip codes (Hannibal MO, Pittsfield IL, and Mt Sterling IL) each contribute more than 2% of the patients having outpatient surgery performed by a QMG physician.

This significant dispersion of cases over a large geographic area in west central Illinois, eastern Missouri and southeastern Iowa raises the question whether a 21 mile radius should solely be used to decide the case on maldistribution. It is the current regulation. The fact is that a large volume of QMG's patients come from an area with a population of about 400,000. This is the area within 50 and 75 miles from the project site, served by 12 QMG office locations. It is this coverage by QMG at the 12 office locations that generates a significant volume included in the projected utilization of the proposed ASTC.

If this perspective is considered, the calculation of ratios shows that the proposed project does not result in a ratio of surgical/treatment stations in ASTCs that exceeds the State's ratio by 1.5 times:

a) $$\frac{\text{7 rms (Blessing ASTC 3 ORs and 4 proc rms) + 8 rms (proposed ASTC)}}{\text{400,000 population}}$$

= **0.0375** rooms per 1,000 population

b) $$\frac{\text{380 ORs + 146 procedure rooms (State totals, year 2016, HFSRB ASTC profiles)}}{\text{12,978,800 population, State of Illinois}}$$

= **0.0405** rooms per 1,000 population

The calculations show that the ratio of ASTC surgical and procedure rooms (including the proposed project) in the 400,000 area is less than the State average. These calculations do not include the ASTCs in Springfield, because they are more than 100 miles from the proposed site (and outside the 400,000 population geographic area), and does not include ASTCs in Missouri or Iowa that are outside the jurisdiction of HFSRB.

2) Four of five ASTCs in HSA are located in Springfield, with only one serving the western area of the HSA.

Even though the Health Service Area (HSA 3) is not the planning area, analysis of the distribution of ASTCs in HSA 3 is informative. There are 5 ASTCs in HSA 3. Four of these are in Springfield (**Orthopaedic Surgery Center of Illinois, Prairie Diagnostic Center at St John's Hospital, Springfield Clinic Ambulatory Surgery, and St John's Surgery Suites, Montvale.**) The attached map highlights the distribution issues. The only other ASTC in the entire HSA, a large region spanning about 128 miles east to west, and 108 miles north to south, is in Quincy in the west region of HSA 3. Other than the existing hospital-owned ASTC in the western area of HSA 3, there are no ambulatory surgical centers in the vast area west of Springfield. The condition of having 4 ASTCs in Springfield and only one in the remainder of HSA 3 could be considered a maldistribution of service, which the proposed project will address.

3) Operating rooms at the 5 ASTCs in HSA 3 exceed the State's utilization standard.

Collectively, the 5 ASTCs reported a total of 23,519 hours in 12 ORs, or 1,960 hours per room. This is in excess of the utilization standard of 1500 hours per room. This statistic indicates that more ORs are needed to serve the population.

The next page shows the table from HFSRB's *Inventory of Health Facilities and Services and Need Determinations*, 9/1/2017, listing the 5 ASTCs in HSA 3 and their cases and hours.

C. Document that, within 24 months after project completion, the proposed project will a) not lower the utilization of other area providers below utilization standards, and b) not lower the utilization of other GSA facilities that are operating below the utilization standards.

The local hospital (with its hospital ORs and procedure rooms) and the hospital-owned ASTC are the two licensed facilities in the GSA providing surgical/treatment services. The table below shows the volume (hours) of surgical/treatment services at the local hospital and at the hospital-owned ASTC for the years 2013 – 2016, the most recent years available at the time of filing the permit application. (Source: HFSRB Hospital and Ambulatory Surgical treatment Center profiles.)

Blessing Hospital and ASTC Surgical and Procedure Hours
Source: HFSRB Hospital and ASTC Profiles

Year	2013	2014	2015	2016	2016, with estimate for missing data
Blessing Hospital					
ORs - outpatient	3310	3781	4027	4527	4527
Procedure Rooms - outpatient	683	2343	2103	NA	2103
Blessing ASTC					
ORs - outpatient	3568	3666	3752	4283	4283
Procedure Rooms - outpatient	2423	2491	2641	2875	2875
Total outpt surgeries/procedures	9984	12281	12523	NA	13788

There is a gap in **the local hospital's** data for year 2016. No procedure room outpatient cases or hours were reported. In order to gauge the impact of the project, it is necessary to have complete information for year 2016. In the absence of hospital outpatient procedure room hours for 2016, the same volume of 2103 hours in 2015 is used to estimate 2016. This assumption is conservative, since the other three categories of hours all increased from 2015 to 2016. This results in a 13,788 outpatient total of hours for the local hospital in year 2016.

Given the above information, the following assumptions and calculations are made in order to appropriately assess the impact of the project on the local hospital:

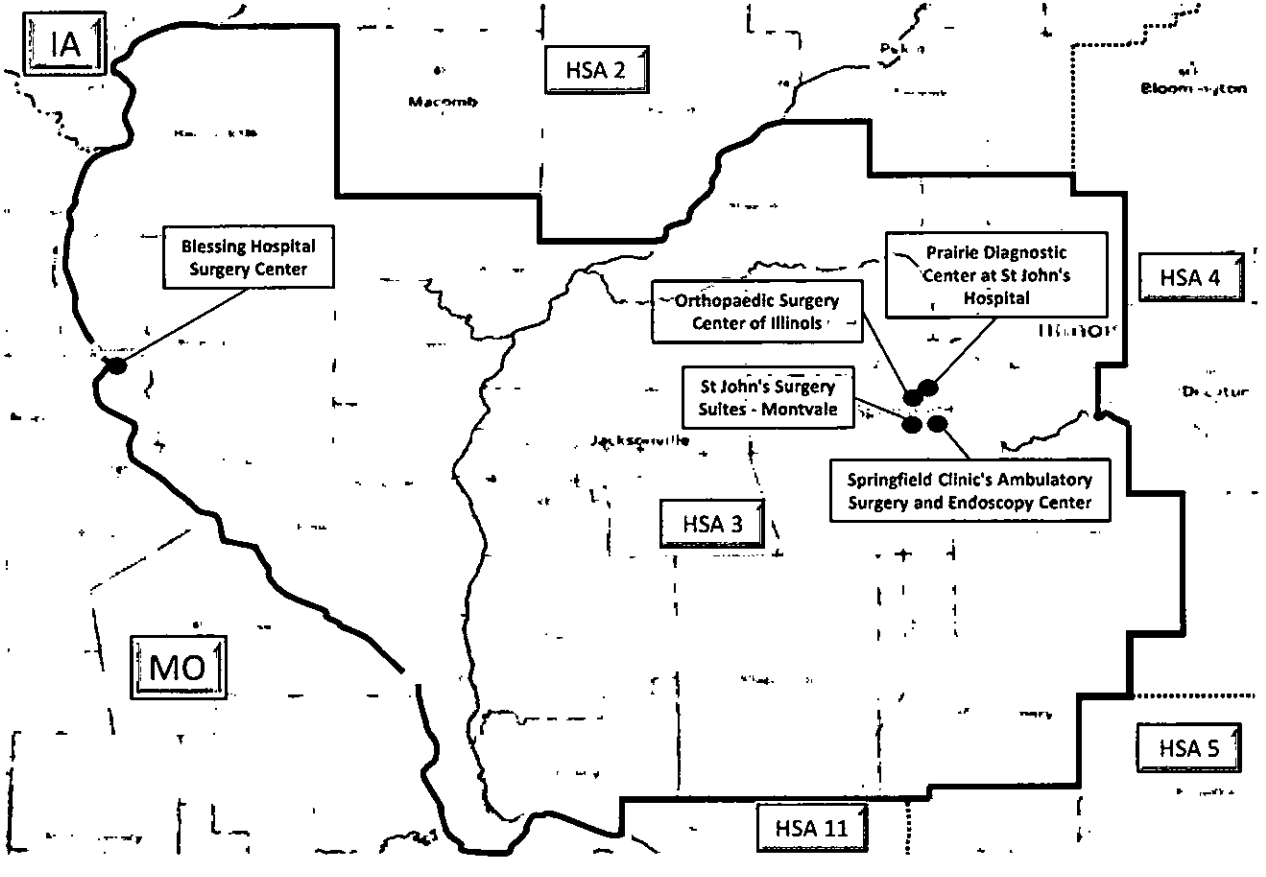
a) **The local hospital's** hours grew by 38.1% between 2013 and 2016.
b) This is an annual average increase of 12.7%.
c) To be conservative, year 2017 volume of 13,788 hours, the same as in year 2016, is assumed.

d) To be conservative, a 10% annual average increase in hours (less than 12.7%) is assumed through 2023 (2 years after completion of the QMG project)
e) 13,788 hours in 2017, increased by 10% per year through 2023, results in a projected 24,426 hours in 2023 for outpatient surgery/treatment at the local hospital and the hospital-owned ASTC.
f) As presented in the Project Services Utilization section of this permit application, QMG projects 10,650 hours at the proposed ASTC at 3347 Broadway in year 2023.
g) Assuming that these 10,650 hours are subtracted from the volume at the local hospital and hospital-owned ASTC, the result is 13,776 hours remaining at the local hospital and its ASTC in year 2023.
h) 13,776 hours is approximately the same as the 13,788 hours estimated at the local hospital in the most recent year.

This information is submitted as documentation that the proposed project will not reduce utilization at the local hospital and its ASTC.

Quincy Medical Group sent a letter to the local hospital as the sole Illinois provider of surgical services located within the GSA. A copy of the letter is included on the following page. The **local hospital's** response will be forwarded to the State upon receipt from Quincy Medical Group. Quincy Medical Group does not believe there will be an adverse impact to patient volumes at the local hospital.

ASTCs in HSA 3



Attachment 24

Ambulatory Surgical Treatment Center	City	Planning Area: 001 Operating Rooms	2015 Surgeries Cases	2015 Surgeries Time(Hrs.)
HAUSER ROSS EYE INSTITUTE SURGERY CENTER	SYCAMORE	4		
10/7/2014 14-033 Received permit to establish a limited-specialty ASTC with 4 operating rooms on Gateway Drive in Sycamore.				
MIDLAND SURGICAL CENTER	SYCAMORE	2	2,999	2,866.00
11/17/2015 E-009-15 Received exemption for change of ownership.				
NORTHPOINTE HEALTH AND WELLNESS CENTER	ROSCOE	2		
6/2/2015 13-072 Received permit to establish a multi-specialty ASTC with 2 operating rooms at 5605 East Rockton Road in Roscoe.				
ROCKFORD AMBULATORY SURGERY CENTER	ROCKFORD	5	5,122	5,292.50
ROCKFORD ENDOSCOPY CENTER	ROCKFORD	2	14,135	6,079.00
ROCKFORD ORTHOPEDIC SURGERY CENTER	ROCKFORD	2	3,470	4,009.75
	PLANNING AREA TOTAL	**17**	**25,726**	**18,247.25**

Ambulatory Surgical Treatment Center	City	Planning Area: 002 Operating Rooms	2015 Surgeries Cases	2015 Surgeries Time(Hrs.)
CENTER FOR HEALTH AMBULATORY SURGERY CENTER, LLC	PEORIA	6	7,340	11,062.00
CENTRAL ILLINOIS ENDOSCOPY CENTER	PEORIA	3	9,413	5,961.75
MUSCULOSKELETAL SURGERY CENTER, LLC	PEORIA	2	676	1,235.85
PEORIA AMBULATORY SURGERY CENTER	PEORIA	1	2,911	2,482.00
PEORIA DAY SURGERY CENTER	PEORIA	4	3,907	5,179.70
RENAL INTERVENTION CENTER, LLC.	MORTON	2	454	538.00
	PLANNING AREA TOTAL	**18**	**24,701**	**26,459.30**

Ambulatory Surgical Treatment Center	City	Planning Area: 003 Operating Rooms	2015 Surgeries Cases	2015 Surgeries Time(Hrs.)
BLESSING HOSPITAL SURGERY CENTER	QUINCY	3	9,823	6,393.00
ORTHOPAEDIC SURGERY CTR. OF IL.	SPRINGFIELD	2	3,554	2,617.00
PRAIRIE DIAGNOSTIC CENTER AT ST JOHN'S HOSPITAL	SPRINGFIELD	2	1,133	38.59
SPRINGFIELD CLINIC AMB. SURG.	SPRINGFIELD	3	20,373	12,834.15
ST. JOHN'S SURGERY SUITES MONTVALE	SPRINGFIELD	2	3,228	1,636.25
	PLANNING AREA TOTAL	**12**	**38,111**	**23,518.99**

Attachment 24

QUINCY MEDICAL GROUP

October 23, 2018

Ms. Maureen Kahn, President
Blessing Hospital
Broadway at 11th Street
Quincy, IL 62301

Dear Ms. Kahn:

This letter is to inform you that Quincy Medical Group (QMG) will be submitting a Certificate of Need permit application to establish an Ambulatory Surgery Treatment Center (ASTC). The ASTC will have 5 Operating Rooms and 3 procedure rooms. One of the five ORs will be dedicated to a cardiac catheterization service.

It is required that we notify all providers of surgery service within 21 miles of the proposed site, 3347 Broadway, and providers of cardiac catheterization within Health Service Area 3 for the catheterization service. We are sending this notice to Blessing Hospital, as the provider of surgical and cardiac catheterization services, as required by regulations of the Illinois Health Facilities and Services Review Board.

Please respond with your statement of the impact of the proposed project on Blessing Hospital's surgical and cardiac catheterization services, and on the Blessing Hospital ASTC at 1118 Hampshire Street.

If you have any questions about this project, please contact me.

Sincerely,

Carol Brockmiller

Carol Brockmiller, CMPE
Chief Executive Officer
Quincy Medical Group
1025 Maine Street
Quincy, IL 62301

1110.235(c)(8) - Staffing

Filling positions and recruiting staff has not been a problem for Quincy Medical Group. With more than 875 employees, QMG is the non-hospital employer of choice in the area for health care professionals. The 2017 employee satisfaction survey from the American Medical Group Association showed Quincy Medical Group to be in the top 5% nationally among AMGA participants.

QMG receives about 5 applications for each RN position posted. Currently at QMG there are 12 RN positions open, with 31 applicants vying for those positions and who have made it through initial screening. There has not been an experienced shortage of RNs seeking employment at QMG. QMG has not found it necessary to use the services of an outside agency to recruit nurses. HR staff and QMG nursing directors have found that specialty nursing positions have the highest volume of applicants. QMG enjoys a very good retention rate, as a result of very selective hiring practices and proven procedures.

The Quincy region has three colleges offering RN education and one offering a surgical technician program. All three colleges have a web board that their alumni access that lists all employment opportunities. In addition to the current QMG staff who seek ways to use their hospital skills and the current area surgical nurses who seek opportunities to end their on-call and weekend responsibilities, QMG continues to work with all local colleges to provide educational experiences to their students and recruit their new graduates.

To lead the staffing plan, QMG will recruit a qualified and experienced administrator (Director) for the surgery center. Dr. John Barbagiovanni DO, will hold the position of Medical Director. Dr. Barbagiovanni is a Board Certified Gastroenterologist with 25+ years' experience. He is active in the community, serving on committees and holding leadership positions in both the Medical Group and hospital settings. Dr. Barbagiovanni is a member of the American Osteopathic Association, the American College of Osteopathic Internists, the American Gastroenterology Association, and the American Society of Gastrointestinal Endoscopy.

There is one x-ray technician program in Quincy; QMG's imaging director keeps a list of technicians waiting for openings at Quincy Medical Group. QMG will employee endoscopy technicians, full-time and part-time RNs and will assure appropriate staffing to meet all physician, patient, and regulatory requirements.

Scheduling and check-in personnel will be recruited from both internal and external sources.

Staffing practices and protocols will be in place at the Surgery Center to assure that the ASTC provides the high level of quality care that the community has come to expect from Quincy Medical Group.

Attachment 24

1110.235(c)(9) - Charge Commitment

The table on the following page represents charges for surgical and treatment procedures at the ASTC at 3347 Broadway.

The letter following that table provides the commitment that these charges will not increase, at a minimum, for the first two years of operation unless a permit is first obtained.

Attachment 24

Table of Proposed Charges

CPT Code	Description	Fee
15823	Revision of upper eyelid	$ 3,780
19301	Partial mastectomy	$ 4,765
21025	Excision of bone, lower jaw	$ 9,913
21040	Excision, benign tumor, mandible	$ 4,406
26055	Incise finger tendon sheath	$ 3,413
28285	Repair of hammertoe	$ 5,922
28299	Correction hallux valgus	$ 5,922
29827	Arthroscop rotator cuff repr	$ 12,592
29828	Arthroscopy biceps tenodesis	$ 12,592
29875	Knee arthroscopy/surgery, synovectomy, ltd	$ 5,922
29880	Knee arthroscopy/surgery w/meniscectomy	$ 5,922
29881	Knee arthroscopy/surgery w/meniscectomy	$ 5,922
31623	Dx bronchoscope/brush	$ 2,722
31624	Dx bronchoscope/lavage	$ 2,722
31628	Bronchoscopy/lung bx each	$ 5,313
31652	Bronch ebus samplng 1/2 node	$ 5,313
33210	Insert/replace temp transvenous single chamber cardiac electrode or pacemaker catheter	$ 18,076
36902	Intro cath to dialysis circuit w/transluminal balloon angioplasty	$ 12,264
41010	Incision of tongue fold	$ 2,743
42820	Remove tonsils and adenoids	$ 5,948
43235	Egd diagnostic brush wash	$ 1,971
43239	Egd biopsy single/multiple	$ 1,971
43249	Esoph egd dilation <30 mm	$ 3,193
43255	Egd control bleeding any	$ 3,193
45331	Sigmoidoscopy and biopsy	$ 1,882
45378	Diagnostic colonoscopy	$ 1,882
45380	Colonoscopy and biopsy	$ 2,483
49505	Prp i/hern init reduc >5 yr	$ 6,474
49585	Rpr umbil hern reduc > 5 yr	$ 6,474
49650	Lap ing hernia repair init	$ 10,188
52332	Cystoscopy and treatment	$ 5,858
52351	Cystouretero & or pyeloscope	$ 3,788
52352	Cystouretero w/stone remove	$ 8,536
52356	Cysto/uretero w/lithotripsy	$ 8,536
58558	Hysteroscopy biopsy	$ 5,451
58571	Tlh w/t/o 250 g or less	$ 16,364
58661	Laparoscopy remove adnexa	$ 10,188
58662	Laparoscopy excise lesions	$ 10,188
60240	Removal of thyroid	$ 9,703

Table of Proposed Charges

62270	Spinal fluid tap diagnostic	$	1,309
63030	Lamnoty incl w/decompression nerve root, 1 instrspc lumbar	$	12,592
63047	Laminec/facetect/foramin, lumbar 1 seg	$	12,592
64721	Carpal tunnel surgery	$	3,998
66984	Cataract surg w/iol 1 stage	$	4,819
G0105	Colorectal scrn; hi risk ind	$	1,882
G0121	Colon ca scrn not hi rsk ind	$	1,882

Surgeries that require implants are subject to additional charges associated with the implants. Implant charges vary based upon what is utilized for any given case and reflect the implants that are used in the actual cases and are billed with a separate HCPCs code. Codes that are **designated as "device intensive" by CMS for ASCs and/or other commercial payors require** implants to be included in the charge at the CPT level; therefore, in those instances, the implant charge will be added to the CPT code charge. For example, if the implant charges are $3,000 for a case, and CMS and/or commercial payor requires it to be added to the procedural charge, the procedural charge will be increased to include the implant charge. This is subject to CMS rules and regulations for specified codes that are adjusted annually, and may also be applicable to commercial payors with similar policies.

QUINCY MEDICAL GROUP

October 12, 2018

Ms. Courtney R. Avery
Administrator
Illinois Health Facilities and
Services Review Board
525 W. Jefferson Street - 2nd floor
Springfield, IL 62761

Re: Charge Commitment

Dear Ms. Avery:

I hereby certify and attest to the understanding that facility charges at the new ASTC will not be increased for at least the first two years of the facility's operation, unless a permit is first obtained pursuant to 77 Ill. Administrative Code 1130.310(a).

If you have any questions, please contact Patty Williamson, Chief Financial Officer, Quincy Medical Group at 217 222-6550.

Sincerely,

Carol Brockmiller

Carol Brockmiller, CMPE
Chief Executive Officer
Quincy Medical Group
1025 Maine Street
Quincy, IL 62301

cc: Patty Williamson, Chief Financial Officer, Quincy Medical Group

1110.235(c)(10) - Assurances

The following letter attests that a peer review program will be implemented, and that the project will meet or exceed utilization standards for surgical/treatment rooms.

Attachment 24

QUINCY MEDICAL GROUP

October 12, 2018

Ms. Courtney Avery
Administrator
Illinois Health Facilities and
Services Review Board
525 W. Jefferson Street - 2nd floor
Springfield, IL 62761

Re: Peer Review / ASTC utilization

Dear Ms. Avery:

I hereby certify and attest that a peer review program will be implemented to evaluate patient outcomes for consistency with quality standards established by professional organizations for the ASTC services, and if outcomes do not meet or exceed those standards, that a quality improvement plan will be initiated.

I also affirm that the ASTC will meet or exceed the utilization standards specified in 77 Ill Administrative Code 110. Documentation submitted with this permit application supports this statement, based on historic growth of outpatient surgical cases conducted by QMG physicians, and commitments by QMG physicians to conduct surgery at the ASTC.

If you have any questions, please contact me at 217 222-6550 x 6455.

Sincerely,

Carol Brockmiller

Carol Brockmiller, CMPE
Chief Executive Officer
Quincy Medical Group
1025 Maine Street
Quincy, IL 62301

Section 1110.270 – Clinical Service Areas Other than Categories of Service – CT Scanner

Attachment 30

Attachment 30
Criterion 1110.270 - Clinical Service Areas Other than Categories of Service

Diagnostic Imaging – CT scanning

The project proposes the installation of a CT scanner. The relevant regulation is 1120.270(c)(2), Service Modernization – Necessary Expansion.

Quincy Medical Group operates a CT scanner at its main facility at 1025 Maine Street, Quincy. The CT service is nearing capacity, as shown on the table below, duplicated from the Project Services Utilization section. The current scanner has accommodated a 55.5% increase in visits from 2013 to 2018, and is nearing capacity. This year, an increasing number of patients requiring a scan the same day as an office visit were not able to be scheduled because of capacity constraints, an indication of the growing volume. The capacity constraint is also reflected in the repressed growth of only 87 patients this year, compared to annual increases of 600 – 800 in the past three years. Unlike inpatient hospital CT services that operate 7 days a week and often 24 hours a day, the office based CT scanner is utilized 5 ½ days a week. As a result, approaching the standard of 7,000 is an indication of high utilization.

The table below shows the average annual growth rate of 11.1% from year 2013 through 2018. Projections for future utilization assume a very conservative 5% annual growth rate, resulting in over 8300 visits in year 2023, two years after project completion.

Year	Historic Utilization (Cases)	Projected Utilization (Cases)	State Standard	Met Standard?
2013	4,186			
2014	4,259			
2015	5,090			
2016	5,750			
2017	6,420			
2018	6,507			
2019		6,832		
2020		7,174		
2021		7,533		
2022		7,909		
2023		8,305	7,000 visits	Yes

There will be no impact on other area providers. All of the historic growth reported above has been internally generated within Quincy Medical Group, and is a result of the growth of its service lines, many of which require CT imaging.

The project further meets the requirement of 1120.270(c)(3)(A) for major medical equipment. Volume will exceed 7,000 needed to justify the addition of a second unit.

Attachment 35 – 1120.130 - Financial Viability

The ratio tests of financial feasibility using the required formulas show that Quincy Medical Group will not meet some of the ratios. This is due to the fact that cash is often used for discretionary distributions to its members and as an opportunity to obtain equipment or pursue facility improvements. QMG does not have the same incentives to retain cash as non-profits do, which helps not-for-profits get more favorable bond ratings. QMG does not have a bond rating.

FINANCIAL VIABILITY

	2014	2015	2016	2017	2023
Current Ratio	1.9	1.8	1.8	1.9	1.7
Net Margin Percentage	1.9%	-2.1%	-0.2%	0.4%	0.6%
Percent Debt to Total Capitalization	56%	62%	62%	64%	63%
Projected Debt Service Coverage	3.42	0.88	1.97	2.16	1.95
Days Cash on Hand	20	3	1	4	9
Cushion Ratio	3.7	0.6	0.2	0.8	1.2

Discretionary cash is spent only when all other financial objectives have been achieved. The following table of ratios shows the results if discretionary cash had been held within the organization. If even a portion of the cash had been retained on the organization's books, all financial ratios would have been achieved. In this case, all financial ratios are met, demonstrating that Quincy Medical Group has financial strength and viability.

FINANCIAL VIABILITY
(adjusted to exclude discretionary distributions to members and other discretionary uses)

	2014	2015	2016	2017	2023
Current Ratio	2.2	1.9	2.0	2.2	1.9
Net Margin Percentage	13.9%	13.2%	11.5%	11.1%	9.9%
Percent Debt to Total Capitalization	56%	62%	62%	64%	63%
Projected Debt Service Coverage	11.99	12.29	9.85	10.21	8.75
Days Cash on Hand	76	68	51	50	74
Cushion Ratio	12.3	12.0	8.1	8.8	8.0

The tables on the following pages present the worksheets showing the ratio calculations. The first page shows the calculations behind the first table above. The second page shows the calculations that support the second table above, associated with the scenario if QMG were to retain cash earnings instead of distributing them among the members or expending them on additional facility or equipment projects.

Attachment 35

FINANCIAL VIABILITY WORKSHEET

	2014	2015	2016	2017	2023
Current Ratio					
Current Assets	33,860,586	29,904,592	29,354,651	32,654,768	40,500,000
Current Liabilities	17,419,122	16,884,470	16,102,835	17,148,548	23,500,000
Add back discretionary distributions to members					
	17,419,122	16,884,470	16,102,835	17,148,548	23,500,000
	1.9	**1.8**	**1.8**	**1.9**	**1.7**
Net Margin Percentage					
Net Income	2,789,272	(3,214,065)	(353,037)	720,830	2,000,000
Add back discretionary distributions to members					
Net Income	2,789,272	(3,214,065)	(353,037)	720,830	2,000,000
Net Operating Revenues	144,152,370	156,326,154	166,367,347	191,156,397	312,166,816
	1.9%	**-2.1%**	**-0.2%**	**0.4%**	**0.6%**
Long-Term Debt to Capitalization					
Long-Term Debt	24,960,427	25,726,254	25,257,954	28,377,140	28,735,085
Long-Term Debt + Net Assets	44,534,508	41,784,147	40,644,187	44,160,080	45,735,085
	56%	**62%**	**62%**	**64%**	**63%**
Projected Debt Service Coverage					
Net Income + (Depr + Interest+ Amort)	6,907,373	1,836,499	4,885,023	5,505,453	8,320,500
Add back discretionary distributions to members					
Net Income + (Depr + Interest+ Amort)	6,907,373	1,836,499	4,885,023	5,505,453	8,320,500
Principal Pmts + Interest for year of Max Debt Service after project completion	2,019,321	2,095,091	2,473,502	2,548,377	4,264,915
	3.42	**0.88**	**1.97**	**2.16**	**1.95**
Days Cash on Hand					
Cash + Investments +Board Designated Funds	7,452,814	1,264,395	463,162	2,041,470	5,000,000
Add back discretionary distributions to members					
Cash + Investments +Board Designated Funds	7,452,814	1,264,395	463,162	2,041,470	5,000,000
(Operating Expense - Depreciation Expense)/365	375,077	433,597	446,344	509,501	538,587
	20	**3**	**1**	**4**	**9**
Cushion Ratio					
Cash + Investments +Board Designated Funds	7,452,814	1,264,395	463,162	2,041,470	5,000,000
Add back discretionary distributions to members					
Cash + Investments +Board Designated Funds	7,452,814	1,264,395	463,162	2,041,470	5,000,000
Principal Pmts + Interest for year of Max Debt Service after project completion	2,019,321	2,095,091	2,473,502	2,548,377	4,264,915
	3.7	**0.6**	**0.2**	**0.8**	**1.2**

FINANCIAL VIABILITY WORKSHEET (*adjusted to exclude discretionary distributions to members and other discretionary uses*)

	2014	2015	2016	2017
Current Ratio				
Current Assets	33,860,586	29,904,592	29,354,651	32,654,768
Current Liabilities	17,419,122	16,884,470	16,102,835	17,148,548
Remove discretionary distributions to members (Dec)	(1,911,397)	(1,265,718)	(1,513,108)	(2,587,036)
Current Liabilities before discretionary distributions to members	15,507,725	15,618,752	14,589,727	14,561,512
	2.2	**1.9**	**2.0**	**2.2**
Net Margin Percentage				
Net Income	2,789,272	(3,214,065)	(353,037)	720,830
Add back discretionary distributions to members	17,300,298	23,902,233	19,488,892	20,510,356
Net Income before discretionary distributions to members	20,089,570	20,688,168	19,135,855	21,231,186
Net Operating Revenues	144,152,370	156,326,154	166,367,347	191,156,397
	13.9%	**13.2%**	**11.5%**	**11.1%**
Long-Term Debt to Capitalization				
Long-Term Debt	24,960,427	25,726,254	25,257,954	28,377,140
Long-Term Debt + Net Assets	44,534,508	41,784,147	40,644,187	44,160,080
	56%	**62%**	**62%**	**64%**
Projected Debt Service Coverage				
Net Income + (Depr + Interest+ Amort)	6,907,373	1,836,499	4,885,023	5,505,453
Add back discretionary distributions to members	17,300,298	23,902,233	19,488,892	20,510,356
Net Income before discretionary distributions to members	24,207,671	25,738,732	24,373,915	26,015,809
Principal Pmts + Interest for year of Max Debt Service after project completion	2,019,321	2,095,091	2,473,502	2,548,377
	11.99	**12.29**	**9.85**	**10.21**
Days Cash on Hand				
Cash + Investments +Board Designated Funds	7,452,814	1,264,395	463,162	2,041,470
Add back discretionary distributions to members	17,300,298	23,902,233	19,488,892	20,510,356
Cash + Investments +Board Designated Funds + Discretionary distribution to members	24,753,112	25,166,628	19,952,054	22,551,826
(Operating Expense - Depreciation Expense-discretionary distributions to members)/365	327,679	368,112	392,950	453,308
	76	**68**	**51**	**50**
Cushion Ratio				
Cash + Investments +Board Designated Funds	7,452,814	1,264,395	463,162	2,041,470
Add back discretionary distributions to members	17,300,298	23,902,233	19,488,892	20,510,356
Cash + Investments +Board Designated Funds + Discretionary distributions to members	24,753,112	25,166,628	19,952,054	22,551,826
Principal Pmts + Interest for year of Max Debt Service after project completion	2,019,321	2,095,091	2,473,502	2,548,377
	12.3	**12.0**	**8.1**	**8.8**

QUINCY MEDICAL GROUP

October 12, 2018

Ms. Courtney Avery
Administrator
Illinois Health Facilities and Services Review Board
525 W. Jefferson Street - 2nd floor
Springfield, IL 62761

Dear Ms. Avery:

Quincy Medical Group is the operating entity and licensee for the Ambulatory Surgical Treatment Center proposed at 3347 Broadway, Quincy, IL. As part of the financial arrangement for the project, Quincy Medical Group will take out a loan of up to $7,000,000.00. Bank of Springfield is the mortgage broker to secure the loan.

The loan will be at the best terms available in the market, offering the lowest net cost.

If you have any questions, please contact Patty Williamson, Chief Financial Officer, Quincy Medical Group at 217 222-6550.

Sincerely,

Carol Brockmiller

Carol Brockmiller
Chief Executive Officer
Quincy Medical Group
1025 Maine Street
Quincy, IL 62301

cc: Patty Williamson, Chief Financial Officer, Quincy Medical Group

C. Reasonableness of Project and Related Costs

COST AND SQUARE FOOT BY DEPARTMENT

	A	B	C	D	E	F	G	H
Department	Cost / Sq Ft *		DGSF		DGSF		Const $	Mod $
	New	Mod	New	Circ %	Mod	Circ %	(A x C)	(B x E)
REVIEWABLE								
ORs and support			10,240	23				
Procedure rms and support			2,410	20				
Recovery			3,685	23				
Cardiac catheterization			1,500	25				
CT scanner			1,550	24				
Total clinical services			19,385	23				
NON-REVIEWABLE								
Lobby, reception, waiting			1,690					
Public toilets, family room			500					
Lockers and lounge			925					
Storage			781					
Conference room			630					
Medical records			545					
Mech, bldg syst, hskeep			978					
Circulation			1,416	100				
Total non-clinical areas			7,465	19				
TOTAL PROJECT			26,850	22				

* Note: Construction and contingency costs are incorporated into the lease for space, and are paid out over the lifetime of the lease. Specific figures for construction and contingency are not available.

Attachment 36

PROJECT COSTS AND SOURCES OF FUNDS

	Clinical	Non-Clinical	Total
Use of Funds			
Pre-Planning Costs	55,584	13,896	69,840
Site Survey and Soil Investigation*			-
Site Preparation*			-
Off-Site Work*			-
Modernization contracts*			-
New Construction contracts*			-
Contingencies*			-
A/E fees*	20,083	5,021	25,104
Consultant fees	352,291	88,073	440,364
Movable Equipment	4,456,026	394,716	4,850,742
Bond Issuance Expense			-
Net Interest Expense during const*			-
FMV Leased space or equipment			-
Leased Space	8,575,924	3,302,516	11,878,440
Leased Equipment	944,928		944,928
Other capital costs - IT	750,000	335,000	1,085,000
Other capital costs - Artwork		125,000	125,000
Other capital costs - Signage		100,000	100,000
Acquisition of Building			-
Total Uses of Funds	15,154,836	4,364,222	19,519,058
			-
Source of Funds			-
Cash and Securities	1,469,163	297,933	1,767,096
Pledges			-
Gifts and Bequests			-
Cond Issues (project related)			-
Mortgages	4,164,820	763,773	4,928,593
Leases (fair market value)	9,520,852	3,302,516	12,823,368
Governmental Appropriations			
Grants			
Other Funds and Sources			
Total Sources of Funds	15,154,836	4,364,222	19,519,058

Note: Site Survey and Soil Investigation, Site Preparation, Off-Site Work, New Construction Contracts, Contingencies, and the bulk of A/E fees and Net Interest Expense During Construction are included in the Fair Market Value of the lease of space.

Itemization of Project Costs and Sources of Funds

The table on the preceding page lists all costs associated with the project.

Itemization of each line item noted in the table is provided below:

Preplanning Costs
$69,480

Costs include consulting fees related to the development of financial feasibility studies and detailed pro forma of the project.

Architect/Engineering Fees
$25,104

This work includes consultation services, preliminary building analysis, program development and preliminary floor layouts with adjacencies. Schematic design, design development, and construction documents will be the responsibility of the building owner; costs of these A/E services will be incorporated into the lease payments.

Consultant Fees
$440,364

Costs include strategic planning, legal consultation, certificate of need application preparation, other regulatory planning, and permit application fees.

Moveable Equipment
$4,850,742

Clinical Equipment	**$4,456,026**
ASTC Equipment	$2,542,508

ASTC Moveable Clinical Equipment includes anesthesia machines, surgical lights, patient monitors, instrument sterilizers, stretchers, surgical tables, video systems, glaucoma laser system and phacoemulsifier for ophthalmology, and instruments for each surgical specialty that the ASTC serves. Additional surgical equipment is to be obtained by lease, and is described below. The FMV of this leased equipment for the 7 surgical and procedure rooms totals $944,928. Consequently, the total value of equipment for the 7 rooms is $3,487,436. The 8th room is to function as a catheterization service; its equipment costs are separated from the surgical room costs, as reported below.

Cath Equipment	$1,247,143

Cath Moveable Clinical Equipment includes a fixed C-arm, hemo system, cardiac ultrasound, anesthesia machine, patient monitors, stretchers, surgical light source, procedure table and table drapery radiation shield.

CT Equipment $666,375

CT Moveable Equipment includes a CT machine, installation, and room supplies.

Non-Clinical Equipment $394,716

Moveable Non-Clinical Equipment includes chairs, tables, desks, staff break room furniture and appliances, copiers, office equipment, and shelving.

FMV of Leased Equipment
$944,928

This equates to the fair market value of leased ASTC clinical equipment which includes two (2) C-Arm machines and endoscopy scopes and related system support equipment. This amount added to the cost of the Moveable ASTC Clinical Equipment is $3,487,436.

FMV of Leased Space
$11,878,440

This equates to the fair market value of the lease for space for the project.

Other Capital Costs
$1,085,000

Clinical IT Costs $750,000

This includes Epic software system build and training.

Non-Clinical IT Costs $335,000

These costs include IT network and desktop hardware and installation and communications system and installation.

Other Capital Costs – Artwork $125,000

Cost of artwork for the new facility.

Other Capital Costs – Signage $100,000

Cost of signage for the new facility.

D. Project Operating Costs

Project Direct Operating Expenses - FY 2023

	Project
Total Operating Costs	13,113,821
Outpatient surgical cases + procedures + caths	16,892
Direct Cost per surgical case + procedure + cath	776.33

E. Total Effect of the Project on Capital Costs

Projected Capital Costs - FY 2023

	Project FY 2023	Total QMG FY 2023
Total pt visits + procedures + dx tests(All QMG)	16,892	858,777
Total Project Cost	19,519,058	--
Useful Life (weighted average)	14.53	--
Total Annual Depreciation	1,771,018	5,271,018
Depreciation Cost per total visits + proc + dx tests	104.84	6.14

Attachment 37 – Safety Net Impact Statement

This safety net impact statement addresses the following requirements:

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.

The project is expected to significantly improve accessibility to high quality, lower-cost ASTC services for Quincy Medical Group existing patients and residents in Quincy and the surrounding communities. The project will not have an adverse impact on essential safety net services in the community.

Quincy Medical Group physicians see all patients, regardless of insurance coverage. Approximately 50% of visits are Medicare patients, and 10% of visits are Medicaid patients – a high percentage compared to large physician groups. Through 6 of its 12 practice sites, Quincy Medical Group provides a significant amount of clinical care to rural residents of west-central Illinois. All of the rural communities covered by these 6 sites have populations under 5,000, and most are under 2,500. Additionally, Quincy Medical Group physicians provide care to patients at designated rural health clinics (RHCs) in the Quincy area. RHCs enhance the provision of primary care services in underserved urban and rural communities. RHCs utilize a sliding fee scale with varying discounts available based on patient family size and income in accordance with federal poverty guidelines. Revenues generated from the proposed project will enable Quincy Medical Group to continue serving these communities.

Four of the 5 ASTCs in HSA 3 are located in or around Springfield, and only 1 is located in Adams County. The proposed project will increase the range of surgical specialties and procedures available and capable of being performed in an ASTC in Adams County as the project will enable Quincy Medical Group specialists to perform numerous procedures that are not available and/or offered at the local hospital-owned ASTC. Expanding the range of surgical specialties offered in Adams County, in conjunction with increasing accessibility to ASTC services, the project will expand access to high quality, lower cost surgical care for Quincy and the surrounding communities in Adams County.

Quincy Medical Group, through its foundation, Quincy Medical Group Healthcare Foundation (Foundation), also provides important and significant benefits to Quincy and the surrounding community. The Foundation was founded in 2010 and is funded by Quincy Medical Group - through its employees and services, and through an annual campaign of its physicians. As a for-profit organization, Quincy Medical Group does not, and is prohibited from, benefiting in any way from the Foundation. Today, the Foundation sponsors, partners, and hosts many Quincy Medical Group events each year, one of which is the Bridge the Gap to Health Race, which is currently in its 19th year. **The proceeds from each year's race are distributed in full to a local** medication assistance program, which helps local patients access needed medications they otherwise cannot afford. In 2018, the Foundation began a focused effort through **Quincy's local Farmers' Market,** whereby the Foundation works with area farmers to feature their produce, provide healthy recipes, and educate on the importance of nutrition. As Quincy Medical Group **grows, the Foundation's resources will grow, allowing the Foundation to continue investing into** Quincy and its neighboring communities for years to come.

2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.

As noted in Attachment 24, the applicant does not believe the project will reduce the outpatient surgical volume at the local hospital or its ASTC below the current (2016) level. The applicant does not believe the project will impair the local hospital's ability to subsidize its safety net services.

3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

The applicant is not proposing the discontinuation of a facility or service.

This safety net impact statement also addresses the following requirements:

1. **For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant.**

See attached table.

2. **For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients.**

See attached table.

3. **Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.**

Not applicable.

Attachment 37 - Safety Net Impact Statement

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**2015**	**2016**	**2017**
Inpatient	-	-	-
Outpatient	155	167	150
Total	155	167	150
Charity (cost In dollars)			
Inpatient	-	-	-
Outpatient	$134,043	$134,150	$40,847
Total	$134,043	$134,150	$40,847
MEDICAID			
Medicaid (# of patients)	**2015**	**2016**	**2017**
Inpatient	-	-	-
Outpatient	12,580	13,608	14,892
Total	12,580	13,608	14,892
Medicaid (revenue)			
Inpatient	-	-	-
Outpatient	$33,063,121	$37,130,298	$42,413,117
Total	$33,063,121	$37,130,298	$42,413,117

Attachment 38 - Charity Care Information

CHARITY CARE			
	2015	2016	2017
Net Patient Revenue	$149,229,598	$158,444,090	$181,722,939
Amount of Charity Care (charges)	$916,221	$771,470	$445,720
Cost of Charity Care	$134,043	$134,150	$40,847

INDEX OF APPENDICES

APPENDIX LETTER	DESCRIPTION	PAGES
Appendix A	Articles regarding cardiac catheterization in surgical centers, and articles regarding quality care and cost savings in ASCs	139-165
Appendix B	Table - Medicare Codes – ASC Savings Opportunity	166-204

MEDTECHDIVE

BRIEF

CMS pitches covering cardiac catheterization at surgical centers

By Susan Kelly

Published July 30, 2018

Dive Brief:

- CMS is proposing to add 12 cardiac catheterization procedures to its coverage list for ambulatory surgical centers (ASC) as the agency looks to accelerate a shift to the lower-cost settings. The changes are part of a broader proposed rule that would revise the Medicare hospital outpatient prospective payment system (OPPS) and ASC payment system for 2019.
- CMS estimated that if 5% of cardiac catheterization procedures migrated from the hospital outpatient setting to the ASC setting as a result of the proposed policy, Medicare payments would be reduced by about $35 million in 2019, and total beneficiary co-payments would decline by about $14 million.
- The agency said it has assessed each of the procedures against the regulatory safety criteria and believes they may be appropriately performed in an ASC. CMS is requesting comments from stakeholders on any specific safety concerns related to performing the 12 cardiac catheterization procedures in an ASC, due Sept. 24.

Dive Insight:

Appendix A

More and more outpatient surgical procedures are being performed at non-hospital facilities such as freestanding ambulatory surgical centers and physician offices, instead of in hospital-based departments. Amid the shift, some hospitals and health systems have acquired ambulatory surgery centers or formed joint ventures with surgeons in these centers.

Cardiac catheterization is often done on an outpatient basis at the hospital to detect or evaluate heart conditions. The procedure involves advancing a small catheter to the heart from a vessel in the groin or the arm. CMS said the 12 cardiac procedures it would add to the ASC coverage list are not expected to require active medical monitoring and care of the patient following the procedure.

CMS said the changes would mean lower costs for patients. Beneficiary coinsurance is always 20% for procedures in ambulatory centers but ranges from 20% to 40% for outpatient procedures performed in hospitals. In addition, ASC payment rates are almost always lower than OPPS rates for the same procedures, CMS said.

Hospitals and surgeons are also watching CMS coverage changes on lucrative total knee replacement procedures. CMS removed total joint replacements from the inpatient-only list in 2018, and in July proposed adding the procedures to the ASC coverage list. CMS is seeking comments on that proposal until Sept. 11.

Jefferies analysts expect CMS will eventually add coverage for knee replacements at ambulatory surgical centers.

"We continue to believe that total knee replacements are likely to be added to the ASC covered procedure list in 2020 or 2021 based on the procedure's removal from the Inpatient-only list in last year's payment rule, and that total and partial hip replacements are likely to soon follow, given that these

Appendix A

procedures are routinely performed in ASCs on non-Medicare patients," the analysts said in a research note.

Recommended Reading:

CMS
Medicare Program: Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs

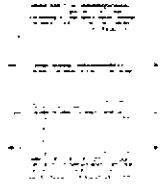
Appendix A

Published on *Cath Lab Digest* (https://www.cathlabdigest.com)

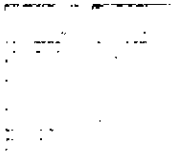
Cardiovascular Procedures 2019: Is the Future Here?

Author(s):
Marc Toth, CEO, ACA Cardiovascular, Tucson, Arizona

Issue Number: Volume 26 - Issue 9 - September 2018 [1]



[2]As our healthcare industry evolves and innovates, providers, payers, life sciences companies, and the government are facing challenges every day. Key stakeholders are working to improve care and outcomes, while reducing costs and spending. A part of that innovation includes transformational technologies and clinical trends impacting the cardiovascular market. One new trend beginning to cement itself as a rock-solid strategy is the evolution of the cardiovascular hybrid ambulatory surgery center (ASC).



[3]Centers for Medicare and Medicaid Services (CMS) recently published the 2019 Proposed Payment Schedule for Hospital Outpatient Services and Ambulatory Surgery Centers, which will be finalized in November and go into effect January 1, 2019. As per usual, there are rate fluctuations in many codes that send every doctor, special interest, and industry group scrambling to understand the impact on their particular site of service. In the cardiovascular space, new coronary procedure codes have been proposed for the ASC, and we can see volatility in the physician office and ASC rates for peripheral arterial disease (PAD) and fistula work.

CMS comments in the Proposed 2019 ASC rule note:

"We are proposing to update the list of ASC-covered surgical procedures by adding 12 cardiac catheterization procedures... After reviewing the clinical characteristics of these procedures and consulting with stakeholders and our clinical advisors, we determined that these 12 procedures are separately paid under the OPPS, would not be expected to pose a significant risk to beneficiary safety when performed in an ASC, and would not be expected to require active medical monitoring and care of the beneficiary at midnight following the procedure."

Appendix A

Many insiders are articulating the idea that adding these procedures well may be a test to see how well the migration to outpatient for low-risk diagnostic caths will be handled by physician groups, as well as patients. The outpatient migration of PAD procedures from the hospital to the office-based lab (OBL) over the past 10 years has demonstrated how these procedures can be performed safely and comfortably in an outpatient setting.

The addition of the ASC site of service (or creating a hybrid OBL/ASC) will allow cardiologists to offer versatility and diversify procedures. This strategy allows risk mitigation when CMS dramatically changes payment rates and can put cardiologists back into the driver's seat in the delivery of innovative, high-quality cardiovascular care.

Heart Care Centers of Illinois was founded in the 1970's to meet the growing demand for convenient cardiac care in their community. The group has always advanced care in optimized settings and offer services with top-tier outcomes. Dr. Robert Iaffaldano, medical director of a new ASC for cardiovascular care for his practice, notes, "Cardiovascular care of the future will be in the care setting most appropriate for the patient and the procedure being done. Twenty years ago, no one could have imagined restoring blood flow to a limb with ischemia outside of the hospital. Today that is the most common site for these types of procedures. Private insurances have always been supportive of this type of innovation, so it is good to see Medicare/CMS take a step toward cardiac cath outside of hospital settings."

The history and evolution of the ASC has favored an expanding scope of service. As operators, tools, and technology have advanced, the ASC has consistently become a safer and more cost-effective site of service for procedures. In addition to venous and dialysis vascular access work, the cardiovascular procedure outpatient shift accelerated with the migration of electrophysiology implantable procedures and PAD procedures to the outpatient site of service. The continuing advancement of minimally invasive services into the ASC is evident with the proposed addition of diagnostic coronary caths for 2019.

There has been a flurry of articles related to the outpatient migration of cardiovascular services. The shifting of percutaneous coronary intervention (PCI) and other cardiovascular procedures to the ASC could be considered a logical progression, based on the following reasons:

1) Safety;

2) Improved patient experience;

3) Cost;

4) CMS already moving in this direction;

5) Commercial payers already supporting this strategy;

6) Procedures in ASCs support the goals of accountable care organizations (ACOs) and value-based models of care.

These arguments, and the proposed approval of diagnostic coronary caths in 2019, are paving the way for an expansion of cardiovascular services in the ASC setting. CMS responded to input from stakeholders that certain procedures outside the Current

Appendix A

Procedural Terminology (CPT) surgical range, but similar to surgical procedures currently covered in an ASC setting, should be ASC-covered surgical procedures. More specifically, stakeholders recommended adding certain cardiovascular procedures to the ASC Covered Procedures List (CPL), due to their similarity to currently covered peripheral endovascular procedures in the surgical code range for surgery and cardiovascular systems. Based on this review, CMS is proposing to update the list of ASC-covered surgical procedures by adding 12 cardiac catheterization procedures to the list for CY 2019 (Table 1).

CMS has determined that these 12 procedures are separately paid under the Medicare Hospital Outpatient Prospective Payment System (OPPS), would not be expected to pose a significant risk to beneficiary safety when performed in an ASC, and would not be expected to require active medical monitoring and care of the beneficiary at midnight following the procedure. CMS seems willing to tread into this domain, with their eye on safety and cost to the system.

With the clinical success of diagnostic cardiac procedures performed safely in the ASC, this will quickly open the door to PCI. Notably, CMS published the following addendum to the Professional Fee Schedule for 2019 (Table 2). Is this foreshadowing the approval of PCI? Many applaud CMS' focus on the "continuum of care" for patients. Why allow a diagnostic angiogram and not allow the intervention in the same site of service?

We have seen rapid approval progression in other specialties such as orthopedics, which now allows total joint replacements and level 1 spinal fusion in the ASC setting. If you can replace hips and knees and fuse the spine in an ASC, why couldn't interventionists deploy a stent? n

ACA Cardiovascular wants to keep you abreast of ambulatory strategies and promote the peer-to-peer learnings of those who begin or already include an ASC as a part of their ambulatory strategy. We are hosting a webinar on 2019 CMS Proposed Payment Schedule for Ambulatory Strategy and the Cardiovascular ASC on September 25th at 1 pm EST.

Visit http://www.acacardiovascular.com/ [4] to learn more, or contact Marc Toth at mtoth@acacardiovascular.com [5].

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Appendix A

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[1] https://www.cathlabdigest.com/issue/35543
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[4] http://www.acacardiovascular.com/
[5] mailto:mtoth@acacardiovascular.com

Appendix A

ASCA Ambulatory Surgery Center Association

Ambulatory Surgery Centers

A Positive Trend in Health Care

Ambulatory surgery centers (ASCs) are health care facilities that offer patients the convenience of having surgeries and procedures performed safely outside the hospital setting. Since their inception more than four decades ago, ASCs have demonstrated an exceptional ability to improve quality and customer service while simultaneously reducing costs. At a time when most developments in health care services and technology typically come with a higher price tag, ASCs stand out as an exception to the rule.

A TRANSFORMATIVE MODEL FOR SURGICAL SERVICES

As our nation struggles with how to improve a troubled and costly health care system, the experience of ASCs is a great example of a successful transformation in health care delivery.

Forty years ago, virtually all surgery was performed in hospitals. Waits of weeks or months for an appointment were not uncommon, and patients typically spent several days in the hospital and several weeks out of work in recovery. In many countries, surgery is still performed this way, but not in the US.

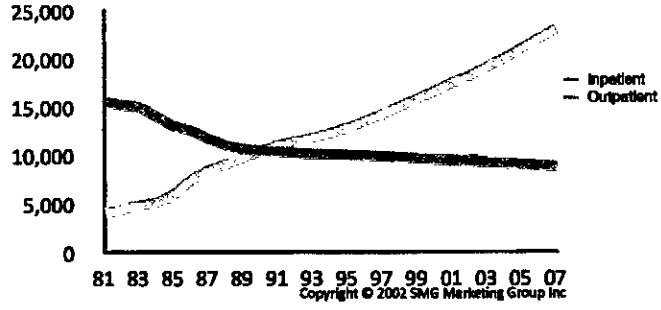
Physicians have taken the lead in the development of ASCs. The first facility was opened in Phoenix, Arizona, in 1970 by two physicians who saw an opportunity to establish a high-quality, cost-effective alternative to inpatient hospital care for surgical services. Faced with frustrations like scheduling delays, limited operating room availability, slow operating room turnover times, and challenges in obtaining new equipment due to hospital budgets and policies, physicians were looking for a better way—and developed it in ASCs.

Today, physicians continue to provide the impetus for the development of new ASCs. By operating in ASCs instead of hospitals, physicians gain increased control over their surgical practices.[1] In the ASC setting, physicians are able to schedule procedures more conveniently, assemble teams of specially trained and highly skilled staff, ensure that the equipment and supplies being used are best suited to their techniques, and design facilities tailored to their specialties and to the specific needs of their patients. Simply stated, physicians are striving for, and have found in ASCs, professional autonomy over their work environment and over the quality of care that has not been available to them in hospitals. These benefits explain why physicians who do not have ownership interest in an ASC (and therefore do not benefit financially from performing procedures in an ASC) choose to work in ASCs in such high numbers.

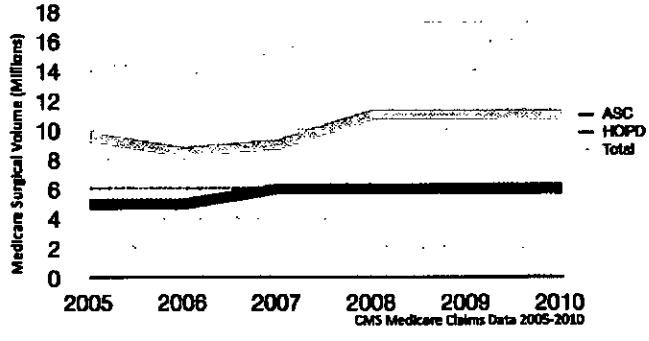
Given the history of their involvement in making ASCs a reality, it is not surprising that physicians continue to have at least some ownership in virtually all (90%) ASCs. But what is more interesting to note is how many ASCs are jointly owned by local hospitals that now increasingly recognize and embrace the value of the ASC model. According to the most recent data available, hospitals have ownership interest in 21% of all ASCs and 3% are owned entirely by hospitals.[2]

ASCs also add considerable value to the US economy, with a 2009 total nationwide economic impact of $90 billion, including more than $5.8 billion in tax payments. Additionally, ASCs employ the equivalent of approximately 117,700 full-time workers.[3]

Surgical Trends by Volume



ASC vs. HOPD Volume



Appendix A

ASCs PROVIDE CARE AT SIGNIFICANT COST SAVINGS

Not only are ASCs focused on ensuring that patients have the best surgical experience possible, they also provide cost-effective care that save the government, third party payors and patients money. On average, the Medicare program and its beneficiaries share in more than $2.6 billion in savings each year because the program pays significantly less for procedures performed in ASCs when compared to the rates paid to hospitals for the same procedures. Accordingly, patient co-pays are also significantly lower when care is received in an ASC.

If just half of the eligible surgical procedures moved from hospital outpatient departments to ASCs, Medicare would save an additional $2.4 billion a year or $24 billion over the next 10 years. Likewise, Medicaid and other insurers benefit from lower prices for services performed in the ASC setting.

Currently, Medicare pays ASCs 58% of the amount paid to hospital outpatient departments for performing the same services For example, Medicare pays hospitals $1,670 for performing an outpatient cataract surgery while paying ASCs only $964 for performing the same surgery.

This huge payment disparity is a fairly recent phenomenon. In 2003, Medicare paid hospitals only 16% more, on average, than it paid ASCs. Today, Medicare pays hospitals 72% more than ASCs for outpatient surgery. There is no health or fiscal policy basis for providing ASCs with drastically lower payments than hospital outpatient departments.

In addition, patients typically pay less coinsurance for procedures performed in the ASC than for comparable procedures in the hospital setting. For example, a Medicare beneficiary could pay as much as $496 in coinsurance for a cataract extraction procedure performed in a hospital outpatient department, whereas that same beneficiary's copayment in the ASC would be only $195.

Without the emergence of ASCs as an option for care, health care expenditures would have been tens of billions of dollars higher over the past four decades. Private insurance companies tend to save similarly, which means employers also incur lower health care costs when employees utilize ASC services. For this reason, both employers and insurers have recently been exploring ways to incentivize the movement of patients and procedures to the ASC setting.

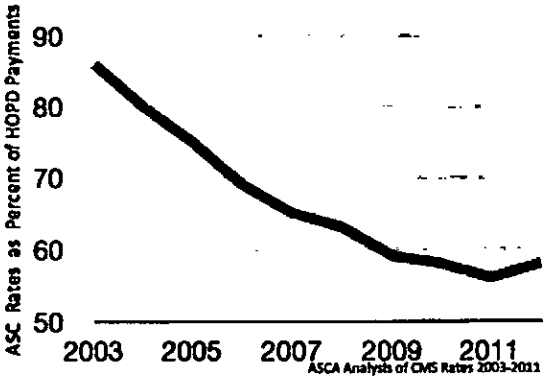
The long-term growth in the number of patients treated in ASCs, and resulting cost savings, is threatened by the widening disparity in reimbursement that ASCs and hospitals receive for the same procedures. In fact, the growing payment differential is creating a market dynamic whereby ASCs are being purchased by hospitals and converted into hospital outpatient departments. Even if an ASC is not physically located next to a hospital, once it is part of a hospital, it can terminate its ASC license and become a unit of the hospital, entitling the hospital to bill for Medicare services provided in the former ASC at the 72% higher hospital outpatient rates.

Cost Comparison:
ASC v. Hospital Outpatient Department

	Patient Cost		Medicare Cost	
	ASC Co-pay	HOPD Co-pay	Total Procedure Cost ASC	Total Procedure Cost HOPD
Cataract	$193	$490	$964	$1,670
Upper GI Endoscopy	$68	$139	$341	$591
Colonoscopy	$76	$186	$378	$655

ASCA Analysis of CMS Rates Effective 1 Jan. 2012

The Gap Between ASC and HOPD Payments Has Widened Significantly

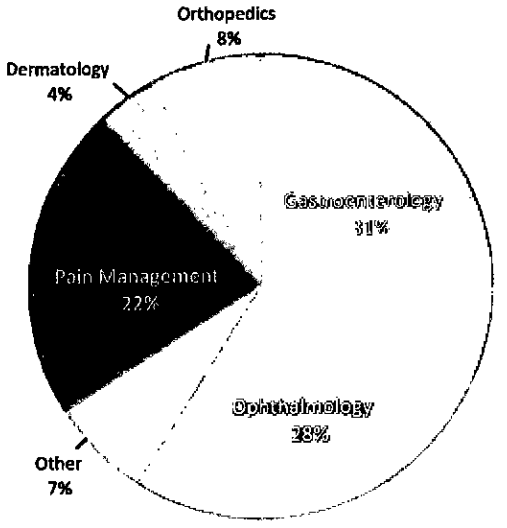


THE ASC INDUSTRY SUPPORTS DISCLOSURE OF PRICING INFORMATION

Typically, ASCs make pricing information available to their patients in advance of surgery. The industry is eager to make price transparency a reality, not only for Medicare beneficiaries, but for all patients. To offer maximum benefit to the consumer, these disclosures should outline the total price of the planned surgical procedure and the specific portion for which the patient would be responsible. This will empower health care consumers as they evaluate and compare costs for the same service amongst various health care providers.

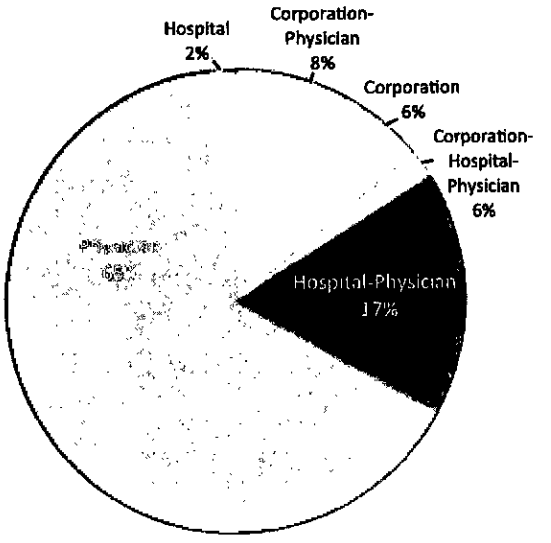
Appendix A

Medicare Case Volume by Specialty



ASCA Analysis of CMS Claims Data 2010

ASC Ownership



ASCA's 2011 ASC Employee Salary & Benefits Survey

ASCs = Efficient Quality Care + Convenience + Patient Satisfaction

The ASC health care delivery model enhances patient care by allowing physicians to:

- Focus exclusively on a small number of processes in a single setting, rather than having to rely on a hospital setting that has large-scale demands for space, resources and the attention of management
- Intensify quality control processes since ASCs are focused on a smaller space and a small number of operating rooms, and
- Allow patients to bring concerns directly to the physician operator who has direct knowledge about each patient's case rather than deal with hospital administrators who almost never have detailed knowledge about individual patients or their experiences

Physician ownership also helps reduce frustrating wait-times for patients and allows for maximum specialization and patient–doctor interaction. Unlike large-scale institutions, ASCs

- Provide responsive, non-bureaucratic environments tailored to each individual patient's needs
- Exercise better control over scheduling, so virtually no procedures are delayed or rescheduled due to the kinds of institutional demands that often occur in hospitals (unforeseen emergency room demands)
- Allow physicians to personally guide innovative strategies for governance, leadership and most importantly, quality initiatives

As a result, patients say they have a 92% satisfaction rate with both the care and service they receive from ASCs .[4] Safe and high quality service, ease of scheduling, greater personal attention and lower costs are among the main reasons cited for the growing popularity of ASCs.

Appendix A

ASCs ARE HIGHLY REGULATED TO ENSURE QUALITY AND SAFETY

ASCs are highly regulated by federal and state entities. The safety and quality of care offered in ASCs is evaluated by independent observers through three processes: state licensure, Medicare certification and voluntary accreditation.

Forty three states and the District of Columbia, currently require ASCs to be licensed in order to operate. The remaining seven states have some form of regulatory requirements for ASCs such as Medicare certification or accreditation by an independent accrediting organization. Each state determines the specific requirements ASCs must meet for licensure and most require rigorous initial and ongoing inspection and reporting.

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All ASCs serving Medicare beneficiaries must be certified by the Medicare program. In order to be certified, an ASC must comply with standards developed by the federal government for the specific purpose of ensuring the safety of the patient and the quality of the facility, physicians, staff, services and management of the ASC.The ASC must demonstrate compliance with these Medicare standards initially and on an ongoing basis.

In addition to state and federal inspections, many ASCs choose to go through voluntary accreditation by an independent accrediting organization. Accrediting organizations for ASCs include The Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC), the American Association for the Accreditation of Ambulatory Surgery Facilities (AAAASF) and the American Osteopathic Association (AOA). ASCs must meet specific standards during on-site inspections by these organizations in order to be accredited. All accrediting organizations also require an ASC to engage in external benchmarking, which allows the facility to compare its performance to the performance of other ASCs.

In addition to requiring certification in order to participate in the Medicare program, federal regulations also limit the scope of surgical procedures reimbursed in ASCs. Even though ASCs and hospital outpatient departments are clinically identical, the Center for Medicare & Medicaid Services (CMS) applies different standards to the two settings.

ASCs: A COMMITMENT TO QUALITY

Quality care has been a hallmark of the ASC health care delivery model since its earliest days. One example of the ASC community's commitment to quality care is the ASC Quality Collaboration, an independent initiative that was established voluntarily by the ASC community to promote quality and safety in ASCs.

The ASC Quality Collaboration is committed to developing meaningful quality measures for the ASC setting. Six of those measures have already been endorsed by the National Quality Forum (NQF). The NQF is a non-profit organization dedicated to improving the quality of health care in America, and the entity the Medicare program consults when seeking appropriate measurements of quality care. More than 20% of all ASCs are already voluntarily reporting the results of the ASC quality measures that NQF has endorsed.

Since 2006, the ASC industry has urged the CMS to establish a uniform quality reporting system to allow all ASCs to publicly demonstrate their performance on quality measures. Starting on October 1, 2012, a new quality reporting system for ASCs will begin and will encompass five of the measures that ASCs are currently reporting voluntarily.

Reporting Measures

Measure	Data Collection Begins
Patient Burn	Oct 1, 2012
Patient Fall	Oct 1, 2012
Wrong Site, Side, Patient, Procedure	Oct 1, 2012
Hospital Admission	Oct 1, 2012
Prophylactic IV Antibiotic Timing	Oct 1, 2012
Safe Surgery Check List Use	Jan 1, 2012
Volume of Certain Procedures	Jan 1, 2012
Influenza Vaccination Coverage for Health Care Workers	Jan 1, 2013

76 Federal Regulation 74492 - 74517

Appendix A

Specific Federal Requirements Governing ASCs

In order to participate in the Medicare program, ASCs are required to meet certain conditions set by the federal government to ensure that the facility is operated in a manner that assures the safety of patients and the quality of services.

ASCs are required to maintain complete, comprehensive and accurate medical records. The content of these records must include a medical history and physical examination relevant to the reason for the surgery and the type of anesthesia planned. In addition, a physician must examine the patient immediately before surgery to evaluate the risk of anesthesia and the procedure to be performed. Prior to discharge each patient must be evaluated by a physician for proper anesthesia recovery.

CMS requires ASCs to take steps to ensure that patients do not acquire infections during their care at these facilities. ASCs must establish a program for identifying and preventing infections, maintaining a sanitary environment and reporting outcomes to appropriate authorities. The program must be one of active surveillance and include specific procedures for prevention, early detection, control and investigation of infectious and communicable diseases in accordance with the recommendations of the Centers for Disease Control and Prevention. Thanks to these ongoing efforts, ASCs have very low infection rates.[5]

A registered nurse trained in the use of emergency equipment and in cardiopulmonary resuscitation must be available whenever a patient is in the ASC. To further protect patient safety, ASCs are also required to have an effective means of transferring patients to a hospital for additional care in the event of an emergency. Written guidelines outlining arrangements for ambulance services and transfer of medical information are mandatory. An ASC must have a written transfer agreement with a local hospital, or all physicians performing surgery in the ASC must have admitting privileges at the designated hospital. Although these safeguards are in place, hospital admissions as a result of complications following ambulatory surgery are rare.[5]

Continuous quality improvement is an important means of ensuring that patients are receiving the best care possible. An ASC, with the active participation of its medical staff, is required to conduct an ongoing, comprehensive assessment of the quality of care provided.

The excellent outcomes associated with ambulatory surgery reflect the commitment that the ASC industry has made to quality and safety. One of the many reasons that ASCs continue to be so successful with patients, physicians and insurers is their keen focus on ensuring the quality of the services provided.

Medicare Health and Safety Requirements

Required Standards	ASCs	HOPDs
Compliance with State licensure law	☑	☑
Governing body and management	☑	☑
Surgical services	☑	☑
Quality assessment and performance improvement	☑	☑
Environment	☑	☑
Medical staff	☑	☑
Nursing services	☑	☑
Medical records	☑	☑
Pharmaceutical services	☑	☑
Laboratory and radiologic services	☑	☑
Patient rights	☑	☑
Infection control	☑	☑
Patient admission, assessment and discharge	☑	☑

Source: 42 CFR 416 & 482

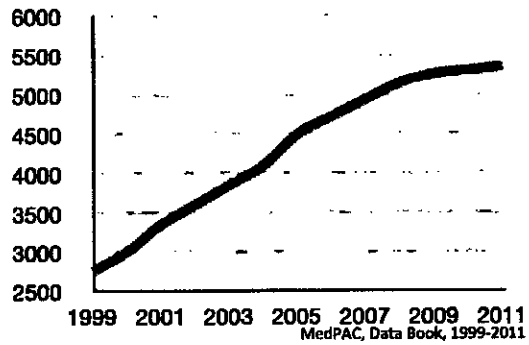
CONTINUED DEMAND FOR ASC FACILITIES

Technological advancement has allowed a growing range of procedures to be performed safely on an outpatient basis (unfortunately, however, Medicare has been slow to recognize these advances and assure that its beneficiaries have access to them). Faster acting and more effective anesthetics and less invasive techniques, such as arthroscopy, have driven this outpatient migration. Procedures that only a few years ago required major incisions, long-acting anesthetics and extended convalescence can now be performed through closed techniques utilizing short-acting anesthetics, and with minimal recovery time. As medical innovation continues to advance, more and more procedures will be able to be performed safely in the outpatient setting.

Over the years, the number of ASCs has grown in response to demand from the key participants in surgical care—patients, physicians and insurers. While this demand has been made possible by technology, it has been driven by patient satisfaction, efficient physician practice, high levels of quality and the cost savings that have benefited all.

However, in a troubling trend, the growth of ASCs has slowed in recent years. If the supply of ASCs does not keep pace with the demand for outpatient surgery that patients require, that care will be provided in the less convenient and more costly hospital outpatient department.[12]

Number of Medicare Certified ASCs



MedPAC, Data Book, 1999-2011

Appendix A

ASCs CONTINUE TO LEAD INNOVATION IN OUTPATIENT SURGICAL CARE

As a leader in the evolution of surgical care that has led to the establishment of affordable and safe outpatient surgery, the ASC industry has shown itself to be ahead of the curve in identifying promising avenues for improving the delivery of health care.

With a solid track record of performance in patient satisfaction, safety, quality and cost management, the ASC industry is already embracing the changes that will allow it to continue to play a leading role in raising the standards of performance in the delivery of outpatient surgical services.

As always, the ASC industry welcomes any opportunity to clarify the services it offers, the regulations and standards governing its operations, and the ways in which it ensures safe, high-quality care for patients.

POLICY CONSIDERATIONS

Given the continued fiscal challenges posed by administering health care programs, policy makers and regulators should continue to focus on fostering innovative methods of health care delivery that offer safe, high-quality care so progressive changes in the nation's health care system can be implemented.

Support should be reserved for those policies that foster competition and promote the utilization of sites of service providing more affordable care, while always maintaining high quality and stringent safety standards. In light of the many benefits ASCs have brought to the nation's health care system, policymakers should develop and implement payment and coverage policies that increase access to, and utilization of, ASCs.

END NOTES

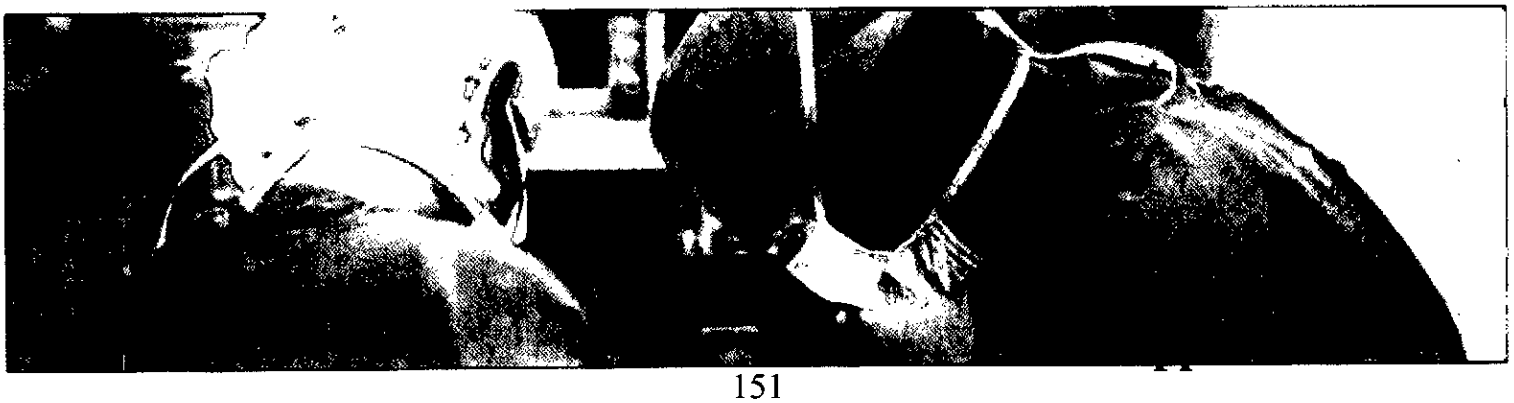
1 "Ambulatory Surgery Centers." Encyclopedia of Surgery. Ed. Anthony J. Senagore. Thomson Gale, 2004.

2 2004 ASC Salary and Benefits Survey, Federated Ambulatory Surgery Association, 2004.

3 Oxford Outcomes ASC Impact Analysis, 2010.

4 Press-Ganey Associates, "Outpatient Pulse Report," 2008.

5 ASCA Outcomes Monitoring Project, 3rd Quarter 2011.



Commercial Insurance Cost Savings in Ambulatory Surgery Centers

Healthcare Bluebook™

ASCA
Ambulatory Surgery Center Association

HealthSmart®

Appendix A

Executive Summary

A review of commercial medical-claims data found that U.S. healthcare costs are reduced by more than $38 billion per year due to the availability of ambulatory surgery centers (ASCs) as an appropriate setting for outpatient procedures. More than $5 billion of the cost reduction accrues to the patient through lower deductible and coinsurance payments. This cost reduction is driven by the fact that, in general, ASC prices are significantly lower than hospital outpatient department (HOPD) prices for the same procedure in all markets, regardless of payer.

The study also looks at the potential savings that could be achieved if additional procedures were redirected to ASCs. As much as $55 billion could be saved annually depending on the percentage of procedures that migrate to ASCs and the mix of ASCs selected instead of HOPDs.

Finally, the study explores additional cost savings that would result if certain inpatient procedures, such as total joint replacements, continue to migrate to ASCs.

This study supplements an earlier review of Medicare costs by researchers at the University of California-Berkeley that showed that ASCs reduce Medicare costs by $2.3 billion annually. *Ambulatory Surgery Center Association, Medicare Cost Savings Tied to ASCs,* (2013), http://www.advancingsurgicalcare.com/medicarecostsavings.

Introduction and Purpose

The Medicare price differential for common outpatient services delivered in the hospital outpatient department (HOPD) vs. ambulatory surgery center (ASC) environment is well known and documented. On average, Medicare reimburses ASCs at 53 percent of the rate it reimburses HOPDs for the same procedure. The payment gap between services delivered at ASCs rather than HOPDs reduced the Centers for Medicare and Medicaid Services' (CMS) costs by more than $7 billion between 2007 and 2011[1].

While CMS payment rates are publicly available, commercial carrier payment rates are not. Therefore, less is known about the price differences and associated savings that exist between the ASC and HOPD environments for those employers and patients covered by commercial insurance (employer-sponsored insurance or private insurance purchased on the public exchanges and elsewhere).

The following analysis provides an estimate of the significant savings that ASCs currently provide to commercially insured patients, along with potential savings available to the commercially insured population, when shifting care to an ASC setting. This analysis was conducted in a partnership between Healthcare Bluebook, the Ambulatory Surgery Center Association (ASCA) and HealthSmart, a leading provider of third-party administrative services for self-funded employers.

Specifically, the paper discusses each of the following:

1. the estimated cost savings generated by ASCs in the commercially insured U.S. population;

2. the estimated additional cost reductions to be achieved if more cases were to be performed in ASCs;

3. the additional value created as traditional inpatient procedures migrate to ASC settings (e.g., total knee replacements); and

4. examples of HOPD and ASC price disparities within and across regions.

The ASC model was developed in 1970, and Medicare approved payments to ASCs for more than 200 procedures in 1982. Steady growth in the number of ASCs and the number of surgical procedures performed in the outpatient setting, including HOPDs, has continued since. This shift toward outpatient procedures has accelerated due to advancements in medical practice and technology that have reduced the need for overnight hospital stays.

[1] Department of Health and Human Services, Office of Inspector General. (2014, April). *Medicare and Beneficiaries Could Save Billions If CMS Reduces Hospital Outpatient Department Payment Rates For Ambulatory Surgical Center Approved Procedures to Ambulatory Surgical Center Payment Rates.* Retrieved April 11, 2016, from http://oig.hhs.gov/oas/reports/ region5/51200020.pdf

Today, many common surgeries are performed as outpatient procedures, and most patients, except those with complicated health conditions, can be served in the outpatient setting. Common ASC procedures include colonoscopies, cataract surgeries, tonsillectomies and arthroscopic orthopedic surgeries. CMS currently approves and reimburses 3,837 procedure codes in the ASC setting, and commercial populations are constantly expanding these boundaries. In fact, some ASCs are performing total joint replacements and other traditionally inpatient procedures with excellent outcomes.

While all HOPDs are hospital owned, most ASCs are at least partially owned by physicians, often in conjunction with hospitals and/or management companies. Sixty-five percent of the more than 5,400 Medicare-licensed ASCs in the U.S. are wholly owned by physicians and operate as small businesses.

A study published in *Health Affairs* analyzed data from the National Survey of Ambulatory Surgery and discovered that procedures performed in ASCs are more efficient, taking 25 percent less time than those performed in hospitals[2]. This efficiency, and corresponding cost-effectiveness, is due largely to the ASCs' focus on a limited number of procedures, their owner/operator culture and specialized nursing and support staff. Because ASCs specialize in providing outpatient surgery, they are able to deliver patient-care services efficiently and conveniently. For example, operating rooms are turned over quickly and are not interrupted by emergency cases. This enables physicians to commence their procedures in a timely manner and use their time more productively. Consequently, ASCs tend to be more convenient and cost effective than HOPDs while still providing excellent care.

[2] Munnich, E. L., & Parente, S. T. (2014). Procedures Take Less Time At Ambulatory Surgery Centers, Keeping Costs Down And Ability To Meet Demand Up. *Health Affairs*, 33(5), 764-769.

Patients Often Pay Dramatically Different Amounts for the Same Care in the Same Community

Healthcare prices vary dramatically even within the same insurance network and city. For example, in Charleston, West Virginia, the price of a cataract surgery, including payments to the anesthesiologist and physician, can vary from $2,684 to $8,662 depending on the facility where the surgery is performed (Figure 1). In this case prices vary by more than 300 percent, primarily due to the amount charged by the facility – not the physicians. These facility prices vary by almost 600 percent and total more than 70 percent of all dollars spent for cataract surgery in Charleston, WV.

Payments to anesthesiologists vary, partially due to the time component of anesthesia billing, but these payments are the smallest portion of the total cost and are dwarfed by payments to facilities.

Payments to physicians are a more significant portion of total cost, but physicians performing the most expensive cataract surgeries are paid approximately the same as physicians performing the least expensive surgeries. Thus, it is the choice of facility that drives the total price variation.

The consistency of payments to physicians indicates that most physicians are unable to differentiate themselves when negotiating payment rates from insurance companies and, hence, are paid similar rates. Facilities, on the other hand, vary significantly in their service

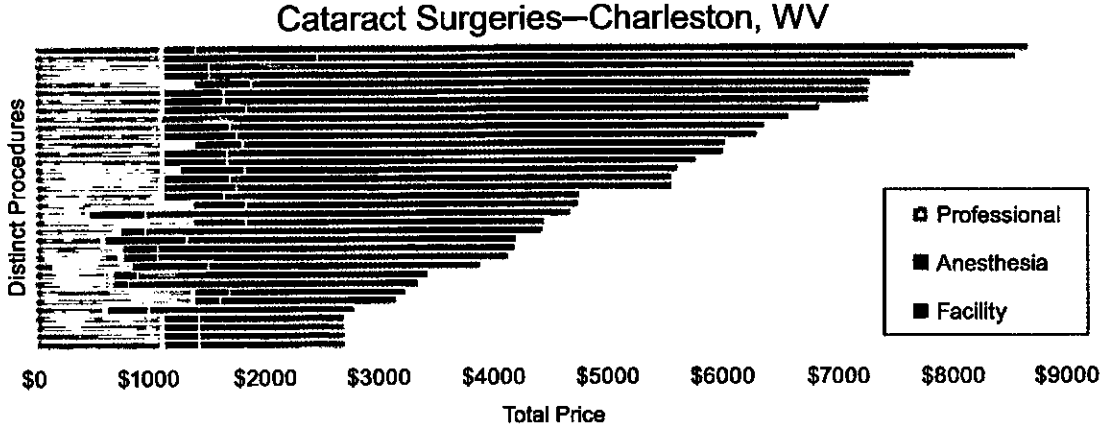


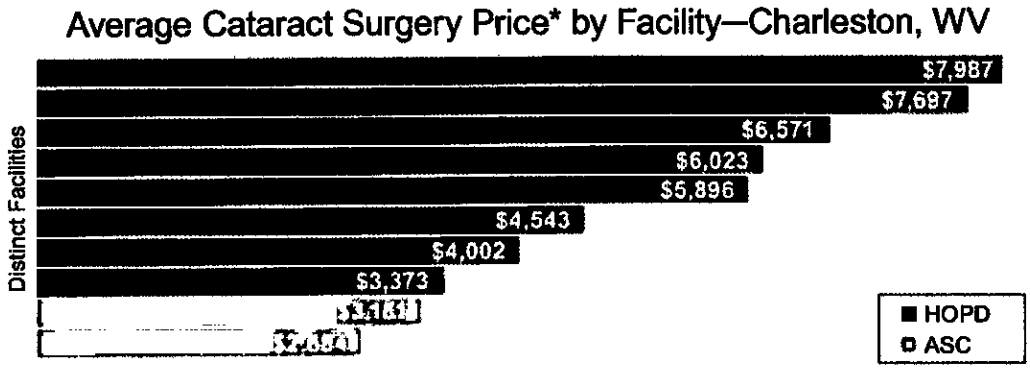
Figure 1

offerings and market power and, therefore, have significantly different negotiated rates with insurance companies.

For example, Hospital A provides emergency, inpatient and outpatient care. Hospital B offers everything Hospital A offers and also operates the only children's hospital in the metropolitan area. Due to this exclusive service line, Hospital B has better negotiating leverage with an insurance company. Importantly, this leverage applies not only to services uniquely performed in the children's hospital, but also to outpatient surgeries, such as cataract surgery, that are performed in other facilities in the area. Since the entire hospital is either in or out of network, all services are negotiated together, allowing Hospital B to demand higher reimbursement for procedures even though equally good, lower-priced alternative sites of service exist in that market area.

Since any ASC will offer fewer services than both Hospital A and B, those ASCs will have less negotiating leverage with commercial carriers and, therefore, often will receive lower reimbursement rates than either Hospital A or B if they want to be included in the insurer's network. While the efficiency inherent in the ASC model explains why ASCs can continue to exist when receiving significantly lower payments, it is the market power of hospitals that widens these price disparities[3] [4].

As a result of these factors, the total price of a procedure performed at an ASC is generally significantly lower than the total price of the same procedure performed in an HOPD. For example, the average price of cataract surgery at an ASC in Charleston, West Virginia, is $2,932, including the physician and anesthesiologist payments, while the average price at an HOPD is $5,762 (Figure 2). In this example,



* Includes allowed amounts for all claim components: anesthesia, professional and facility.

Figure 2

[3] Neprash, H.T., BA, Chernew, M.E., PhD, Hicks, A.L., MS, Gibson, T., PhD, & McWilliams, M., MD, PhD, (2015, October). Association of Financial Integration Between Physicians and Hospitals With Commercial Health Care Prices. *Journal of the American Medical Association.*

[4] The Robert Wood Johnson Foundation, Martin Gaynor, PhD & Robert Town, PhD. (2012, June). *The impact of hospital consolidation – Update.* Retrieved April 20, 2016, from http://www.rwjf.org/en/library/research/2012/06/the-impact-of-hospital-consolidation.htm

the average price for a cataract surgery at the least expensive facility was $2,684, including the payments to anesthesiologists and physicians. At the most expensive facility, the average price was $7,987. ASCs are at the low end of the spectrum and HOPDs are at the high end.

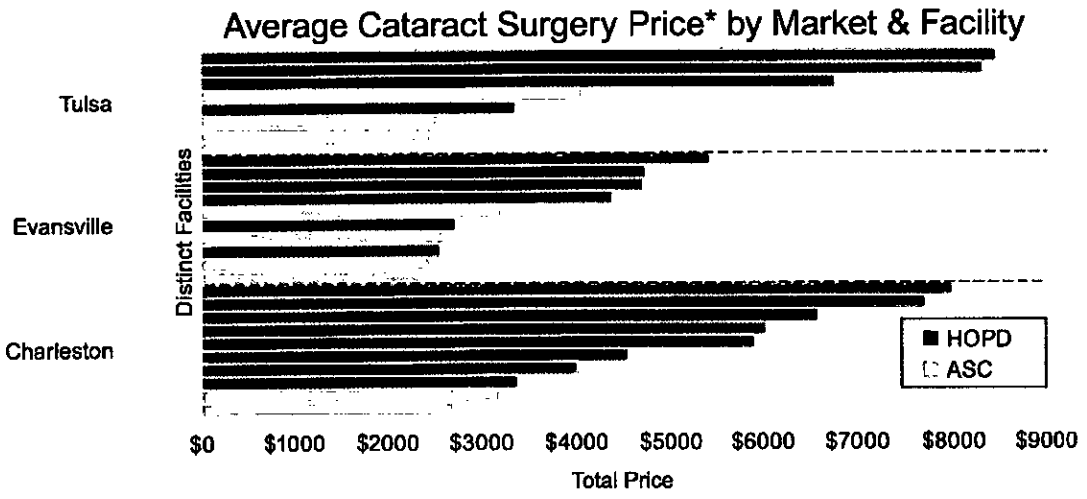
This commercial price differential between the ASC and HOPD environments is persistent across metropolitan areas (Figure 3), insurance carriers and procedure categories, with the degree of price variability related to local market factors.

Summary of Methodology

All analysis was conducted using a sample of de-identified commercial claims data for calendar year 2014 from HealthSmart. This data represents more than 400,000 lives across all regions of the U.S. The CMS list of ASC-eligible procedure codes, with a few additions reflecting those prevalent in a commercial population (pediatric-related codes, OB/GYN-related codes, etc.), was used to identify the spending on procedures that can be performed in an ASC.

Total price of service was included in the analysis (facility fees, professional fees and anesthesia fees, where relevant). Based on the commercial population considered, these services accounted for about 19 percent of total medical spend, or $890 per person for the year. All prices are calculated using the "allowed" amount, which reflects the actual amount a provider received after any discounts were applied.

Thirteen high-volume outpatient procedures were used as proxies to analyze the price differential between the ASC and HOPD environments and estimate the percentage of spending that could be saved by performing the procedures in ASCs instead of HOPDs. An adjustment was made to account for the fact that some high-risk patients are not candidates



* Includes allowed amounts for all claim components: anesthesia, professional and facility.

Figure 3

for ASC-based care (patients with high comorbidities are traditionally directed to an HOPD in order to be closer to critical-access care). This adjusted percentage was applied to the $890 ASC-eligible spend per person and then scaled by the commercially insured U.S. population to estimate the national savings potential.

All estimates are based on the calendar year 2014 data. No adjustments were made to account for population aging or increasing utilization of ASC-eligible services. (See Appendix A: Methodology and Appendix B: Adjustments for ASC Ineligibility for a more detailed explanation of the methodology.)

Current ASC Use Reduces Private Healthcare Costs by $38 Billion Annually

The lower cost of care in ASCs relative to HOPDs saves employers and consumers tens of billions of dollars a year. For the commercially insured population in the U.S., an estimated $37.8 billion is saved annually by using ASCs. Stated differently, if all of the procedures currently performed in ASCs for the commercially insured population in the U.S. were performed in HOPDs, the cost of those procedures would increase by $37.8 billion in just one year.

Annual Savings from Procedures Performed in ASCs	
% of Common ASC Procedures Currently Performed at ASCs	48%
Current Annual Savings	$37.8 B
Potential Additional Annual Savings	$38.2 B
Potential Additional Annual Savings from Optimal Migration to ASCs	$55.6 B

Potential Cost Reductions Attributed to ASCs

Despite the savings detailed above, for commercially insured populations, only 48 percent of procedures commonly performed in ASCs are actually performed in ASCs. If the remaining 52 percent were performed at ASC price points, an additional $41 billion in healthcare costs could be saved annually.

As a practical matter, ASCs would not be the appropriate setting for a small percentage of patients (e.g., those with serious health issues) currently treated in HOPDs. For example, patients on dialysis (0.1 percent of Americans) are not ASC eligible for certain procedures. When ASC-ineligible cases are accounted for, the total potential annual savings from performing the surgeries in ASCs instead of HOPDs is $38.2B. (This assumes 3 percent of relevant cases are ASC ineligible. See Appendix B: Adjustments for ASC Ineligibility.)

The average ASC price, however, is a blend of both lower-priced and higher-priced ASCs. The optimal migration of cases would shift cases from HOPDs to the local low-price ASCs. If patients were directed to low-price ASCs only, the potential annual savings increases from $38.2 billion to $55.6 billion.

Migrating a meaningful number of patients to lower-cost ASC settings would, undoubtedly, also have the added benefit of causing HOPDs

to consider price reductions in order to maintain their market share. While this study did not attempt to model the competitive reactions of HOPDs if confronted with a significant loss of patient volume, fundamental economic principles as well as a recent study that looked at the impact of reference-based pricing on patient choices concluded that hospitals did, in fact, lower their pricing for certain procedures in response to a loss of market share to competing ASCs[6].

Potential Savings Can Grow if ASCs Can Perform More Complex Procedures

With advances in surgical techniques, pain management and post-surgical care, more procedures traditionally performed in the inpatient setting are being shifted to ASCs. This creates an expanding frontier for reducing healthcare costs. As an example, total hip and total knee replacements, which currently account for about 1.5 percent of total medical spend, are now being performed safely in ASCs in a limited number of markets. The potential savings are significant. Assuming that the price differential and the rate of ASC ineligibility due to comorbidities for total joint replacement will be commensurate with other outpatient procedures, $3.2 billion could be saved by moving total hip and knee replacements to ASCs. (See Appendix A: Methodology.)

Projected National Cost Reductions

To realize the potential cost reductions highlighted above, several things need to happen. On the supply side, ASC capacity will have to double in order to support the migration from HOPDs.

On the demand side, patients must be educated and incentivized to choose ASCs for their outpatient procedures. As premiums rise and adoption of high-deductible health plans increases, patients have greater incentives to reduce their costs by choosing ASC-based care, but education is lacking. Though healthcare transparency has made significant advancements in recent years, most patients are still unaware of the lower costs that ASCs offer.

Even modest changes in market share produce massive savings for the entire health system. For example, if an additional 5 percent of current HOPD cases were moved to ASCs annually over the next ten years, $113.8 billion would be saved compared to current utilization rates (Table 1). This assumes that the annual potential ASC savings is currently $41.4 billion:

Ten-Year Savings Projection

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Total
Potential Savings	$41.4 B	$41.4 B	$41.4 B	$41.4 B	$41.4 B	$41.4 B	$41.4 B	$41.4 B	$41.4 B	$41.4 B	$413.7 B
Percent of Savings Captured	5%	10%	15%	20%	25%	30%	35%	40%	45%	50%	28%
Savings	$2.1 B	$4.1 B	$6.2 B	$8.3 B	$10.3 B	$12.4 B	$14.5 B	$16.5 B	$18.6 B	$20.7 B	$113.8 B

Table 1

[6] Robinson, J., et. al. (2015, March). Reference-Based Benefit Design Changes Consumers' Choices And Employers' Payments For Ambulatory Surgery. *Health Affairs.*

$38.2 billion from current ASC-eligible procedures above plus $3.2 billion from total knee and hip replacement.

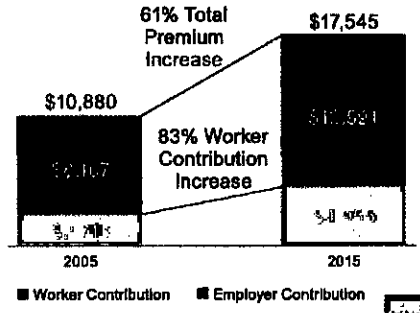
For ASC eligible procedures in this study, patients were responsible for 15 percent of the cost on average. That would mean $17.1 billion in reduced costs for patients over the next ten years (Figure 4). If 3 percent or 8 percent of HOPD cases were moved to ASCs annually, ten-year savings would be $68.3 billion and $182 billion respectively (Table 2).

Projected National Cost Reduction	
Plan Sponsor Savings	$96.7 B
Patient Savings	$17.1 B
Total Savings	$113.8 B

Figure 4

These estimates do not account for inflation or upward trends in medical spending. They also do not take into account the potential that HOPD pricing will decrease in order to compete with ASCs, which would create further outpatient savings. As referenced above, in the CalPERS reference pricing program, high-priced providers will reduce prices to be competitive and attract price-sensitive consumers.

Average Annual Health Insurance Premiums and Worker Contributions for Family Coverage, 2005-2015



SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2005-2015

Reducing Costs for Employers and Employees

From 2005 to 2015, average health insurance premiums for employer-sponsored family coverage increased 61 percent, from $10,880 to $17,545 per year. To combat these rising costs, employers have increasingly adopted Consumer Driven Health Plans (CDHP) and account-based plan types, shifting costs to employees. This has driven the average employee's share of healthcare spending up 81 percent in the same time period, from $2,713 to $4,955[6] annually. This highlights the need for programs like price transparency that can help patients identify better value providers within their networks so that employers and their employees both can lower costs.

Ten-Year Savings Projections

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Total
Savings at 3% Additional Capture	$1.2 B	$2.5 B	$3.7 B	$5.0 B	$6.2 B	$7.4 B	$8.7 B	$9.9 B	$11.2 B	$12.4 B	$68.3 B
Savings at 5% Additional Capture	$2.1 B	$4.1 B	$6.2 B	$8.3 B	$10.3 B	$12.4 B	$14.5 B	$16.5 B	$18.6 B	$20.7 B	$113.8 B
Savings at 8% Additional Capture	$3.3 B	$6.6 B	$9.9 B	$13.2 B	$16.5 B	$19.9 B	$23.2 B	$26.5 B	$29.8 B	$33.1 B	$182.0 B

Table 2

[6] Henry J. Kaiser Family Foundation. (2015, September). *Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2005–2015.* Retrieved April 10, 2016, from http://kff.org/health-costs/report/2015-employer-health-benefits-survey/

For example, in Charlotte, NC, the average ASC price for a knee arthroscopy was $6,118, while the average HOPD price was $12,493, more than twice as expensive. That means $6,375 is saved on average in Charlotte, NC, when a patient chooses an ASC for a knee arthroscopy. How those savings are divided between the payer and the patient depends on the plan design.

For a knee arthroscopy in Charlotte, NC, if a patient has a Silver Plan as defined by the Affordable Care Act, with a $2,700 deductible, 80 percent coinsurance and $5,000 maximum out of pocket, the patient would save $1,275—more than the median family's weekly income. The remaining $5,100 would be saved by the payer. For self-funded employer-sponsored insurance, that is $5,100 directly to the bottom line for the employer.

Applying the same plan design to the earlier example of cataract surgery in Charleston, WV, a patient would save $566 by choosing an ASC instead of an HOPD. This is a significant savings in a geographic area where annual income per capita is less than $35,000[7]. The payer would realize an additional savings of $2,264.

Estimating Savings for Self-Insured Populations

For employers that self insure, it is reasonably straightforward to estimate the potential cost reductions from ASCs for their covered employees. With $890 in ASC-eligible spending per commercially insured person and 20.6 percent savings opportunity from moving all ASC-eligible cases from HOPDs to ASCs, $183 in potential ASC savings exists per commercially insured person. A self-funded employer with 1,000 employees is normally covering more than 2,000 lives, when employees and dependents are counted, which means a potential ASC-based savings of more than $366,000 for the employer and employees.

Conclusion

Billions of dollars spent each year on commercially insured outpatient surgeries and procedures can be reduced, without compromising quality, if more cases migrate to ambulatory surgery centers. While a small percentage of patients have health conditions that require outpatient care to be received in proximity to a full-service hospital should complications arise, most patients can receive the same level of care at lower cost by seeking treatment in an ASC. Advances in medical technology and pain control are allowing increasingly complex procedures, such as total joint replacements, to be performed in an outpatient setting.

Policymakers, insurers, employers and beneficiaries all have a shared interest in reducing healthcare costs, and the $38 billion in annual savings identified in this study highlight the role that ASCs already play in controlling these costs. Strategies should be implemented to generate additional savings by ensuring that the most efficient site of service for outpatient care is selected whenever possible. In particular, innovative plan design and increased consumer awareness of the benefits of receiving care in an ASC can save thousands of dollars per procedure.

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[7] United States Census Bureau. (2014). *2010–2014 American Community Survey 5-Year Estimates.* Retrieved April 30, 2016, from http://www.census.gov/

About the authors/organizations

Ambulatory Surgery Center Association (ASCA)

ASCA is the national membership association that represents ASCs of all specialties and provides advocacy and resources to assist ASCs in delivering high quality, cost-effective ambulatory surgery to all the patients they serve.

Healthcare Bluebook

Healthcarebluebook.com, headquartered in Nashville, TN, is a leading provider of health-care price and quality transparency solutions to employers, third-party administrators (TPA), health plans and provider organizations. Healthcare Bluebook products help employers and employees save money by enabling consumers to understand local health-care prices, compare providers on price and quality and shop for care anywhere in the U.S.

HealthSmart

For more than 40 years, HealthSmart has offered a wide array of customizable and scalable health-plan solutions for self-funded employers. HealthSmart's comprehensive service suite addresses individual health from all angles. This includes claims and benefits administration, provider networks, pharmacy, benefit-management services, business intelligence, onsite employer clinics, care management, a variety of health and wellness initiatives and Web-based reporting.

Appendix A: Methodology

Data Source

All analysis was conducted using a national sample of de-identified commercial claims for calendar year 2014.

Estimating Potential ASC Savings for the Commercially Insured U.S. Population

The estimated potential ASC savings for the commercially insured U.S. population is calculated as:

Equation 1

Addressable Spend per Commercially Insured Person	X	Percent Savings from ASCs	X	Commercially Insured Population
$890		20.6%		208.6M

Estimating the Addressable Spend per Commercially Insured Patient

The addressable spend is the expenditure on any procedure that could be performed in an ASC for an ASC-eligible patient, whether that patient is ASC eligible or not. (Adjustments for ASC ineligible are made later in the process. See Appendix B: Adjustments for ASC Ineligibility.) All prices are calculated using the allowed amount, which is the actual amount a provider receives after any discounts are applied.

CMS currently covers 3,837 procedure codes in the ASC setting. Procedure codes from select Healthcare Bluebook ShopSmart™ procedures were added to the CMS list to produce a complete ASC-eligible procedure code list. These procedure codes were used to identify procedures in one

year of medical-claims data. For each procedure performed in an ASC or HOPD, the total anesthesia, professional and facility payments were included as part of the procedure price. All office-based, inpatient-based and emergent care was excluded. When the total payments from this process were divided by the total members in the represented population, the annual addressable spend per person was $890.

Estimating Percent Savings from ASCs

To estimate the percent savings from ASCs, thirteen high-volume procedures were used as proxies to represent all ASC procedures. These procedures were selected for their high volume and standardization. The average ASC price was calculated for each procedure in each metropolitan market across the U.S.

The potential ASC savings is the sum of the differences between the price of each HOPD case and the average ASC case price for that metropolitan market and procedure combination. Market and procedure combinations with limited data volume were excluded.

Equation 2

$$potential\ ASC\ savings = \sum_{m,p,h} cost_{m,p,h} - average\_ASC\_price_{m,p}$$

m = market
p = procedure
h = HOPD case

To produce the ASC savings as a percentage, the potential ASC savings was divided by the total spend for all analyzed markets and procedures and multiplied by one hundred.

Equation 3

$$percent\ savings\ from\ ASCs = \sum_{m,p,h} \frac{potential\ ASC\ savings}{total\ spend} \times 100$$

Estimating Potential Savings from Total Hip & Total Knee Replacements

To estimate potential savings from moving total hip and knee replacements to the ASC setting, Equation 1 from above was used, but with $73.59 as the addressable spend per commercially insured person. This represents 1.5 percent of total medical spend per commercially insured person. The 20.6 percent savings opportunity was not changed because there are not currently enough markets offering ASC-based joint replacement to use as a representation of the entire U.S. However, the savings opportunity may be as much as double this estimate based on markets that currently have ASC-based total joint replacements.

Appendix B: Adjustments for ASC Ineligibility

Some patients will not qualify for treatment in an ASC setting due to comorbidities or other complicating factors. To account for this, potential ASC savings were estimated using three assumptions for what percent of the commercially insured population is ASC ineligible: 1 percent, 3 percent and 7

percent. These percentages were selected based on prevalence rates for three common conditions that may make patients ineligible for care at an ASC for some procedures (Table 3).

Seven percent ASC ineligibility is the upper limit of this sensitivity analysis since it is the sum of the prevalence rates of all three conditions, which are not independent and which don't necessarily disqualify patients from ASC-based care. For example, a patient with a body mass index (BMI) of 41 could still be cared for in an ASC for most if not all procedures performed in an ASC. However, a patient with a BMI of 45 would qualify for fewer procedures in an ASC setting.

Three percent was selected as the expected rate of ASC ineligibility in a commercially insured population. This, however, could still be an overestimation, so we have also included the one-percent ASC-ineligibility threshold.

For each of these ASC-ineligibility rates, a corresponding number of cases per market/procedure combination were assumed to be performed at the average HOPD price and excluded from the migration calculation. See Table 4 for the sensitivity impact on estimated savings.

Common Conditions that Effect ASC Eligibility

Condition	Prevalence (% of U.S. Population)	Notes
Latex Allergy	< 1%	Some ASCs are not equipped with a latex-free operating room.
CKD (with Dialysis)	0.1%	Not a disqualifying condition for all procedures performed in ASCs.
BMI > 40	6.3%	Patients with BMI > 45 are almost always ASC ineligible. Not all patients with BMI between 40 and 45 are ASC ineligible.

Table 3

Effect of ASC-Ineligibility on Potential Savings

	Savings as % of Total Addressable Spend	Potential Annual Savings
0% ASC Ineligible	22.1%	$41.0 B
1% ASC Ineligible	21.6%	$40.1 B
3% ASC Ineligible	20.6%	$38.2 B
7% ASC Ineligible	18.6%	$34.5 B

Table 4

Appendix C: Savings Examples

Procedure prices in most U.S. markets can vary by as much as 500 percent. In most cases, when present, ASCs provide the best value.

Procedure	Market	Lowest Price Provider Type	Lowest Price	Average ASC Price	Average HOPD Price	Average Price Difference
Cataract Surgery	Charleston, WV	ASC	$2,884	$2,932	$5,762	$2,830
Cataract Surgery	Evansville, IN	ASC	$2,450	$3,316	$6,992	$3,676
Cataract Surgery	Tulsa, OK	ASC	$2,248	$2,249	$3,833	$1,335
Knee Arthroscopy	Fayetteville, NC	ASC	$5,924	$7,658	$11,575	$3,917
Knee Arthroscopy	Charlotte, NC	ASC	$5,664	$6,118	$12,493	$6,375
Knee Arthroscopy	Tulsa, OK	ASC	$2,627	$2,844	$4,807	$1,963
Knee Arthroscopy	Phoenix, AZ	ASC	$2,355	$2,972	$4,306	$1,334

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CPT	2018 Full Description	2018 Medicare Area-Adj. ASC Rate	2018 Medicare Area-Adj HOPD OPPS Rate	2017 Estimated ASC Eligible Medicare Cases [1,2]	Total Projected Cost in ASC	Total Projected Cost in HOPD	Projected ASC Annual Savings based on 2018 ASC vs HOPD rates	ASC Rates as Percent of HOPD	Percent Savings in ASC
66984	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)	$917.95	$1,741.51	1,493	$1,370,912	$2,600,858	($1,229,946)	53%	47%
45385	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	$451.39	$848.86	427	$192,608	$362,209	($169,600)	53%	47%
45380	Colonoscopy, flexible; with biopsy, single or multiple	$451.39	$848.86	329	$148,485	$279,233	($130,748)	53%	47%
43239	Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple	$358.41	$673.99	248	$88,957	$167,284	($78,327)	53%	47%
G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk	$342.25	$643.61	121	$41,310	$77,684	($36,374)	53%	47%
G0105	Colorectal cancer screening; colonoscopy on individual at high risk	$342.25	$643.61	107	$36,655	$68,931	($32,276)	53%	47%
36561	Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; age 5 years or older	$1,201.64	$2,259.72	99	$119,503	$224,729	($105,226)	53%	47%
64721	Neuroplasty and/or transposition; median nerve at carpal tunnel	$726.82	$1,459.95	94	$68,575	$137,746	($69,171)	50%	50%
52356	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double-J type)	$1,625.91	$3,359.59	77	$124,382	$257,009	($132,627)	48%	52%
45378	Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	$342.25	$643.61	73	$25,018	$47,048	($22,029)	53%	47%

Appendix B [1]

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MEDICARE CODES - ASC SAVINGS OPPORTUNITY - BASED ON 2017 EXPERIENCE DATA

CPT	2018 Full Description	2018 Medicare Area-Adj. ASC Rate	2018 Medicare Area-Adj HOPD OPPS Rate	2017 Estimated ASC Eligible Medicare Cases [1,2]	Total Projected Cost in ASC	Total Projected Cost in HOPD	Projected ASC Annual Savings based on 2018 ASC vs HOPD rates	ASC Rates as Percent of HOPD	Percent Savings in ASC
66982	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage	$917.95	$1,741.51	71	$65,542	$124,344	($58,802)	53%	47%
43235	Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	$358.41	$673.99	60	$21,630	$40,675	($19,045)	53%	47%
52648	Laser vaporization of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)	$1,625.91	$3,359.59	57	$92,596	$191,329	($98,733)	48%	52%
52332	Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)	$1,115.88	$2,444.67	54	$59,755	$130,912	($71,157)	46%	54%
36200	Introduction of catheter, aorta	$0.00	$0.00	51	$0	$0	$0	n/a	n/a

Appendix B [2]

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MEDICARE CODES - ASC SAVINGS OPPORTUNITY - BASED ON 2017 EXPERIENCE DATA

CPT	2018 Full Description	2018 Medicare Area-Adj. ASC Rate	2018 Medicare Area-Adj HOPD OPPS Rate	2017 Estimated ASC Eligible Medicare Cases [1,2]	Total Projected Cost in ASC	Total Projected Cost in HOPD	Projected ASC Annual Savings based on 2018 ASC vs HOPD rates	ASC Rates as Percent of HOPD	Percent Savings in ASC
29881	Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	$1,184.43	$2,397.95	38	$45,304	$91,722	($46,417)	49%	51%
45330	Sigmoidoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	$128.26	$643.61	37	$4,797	$24,071	($19,274)	20%	80%
47562	Laparoscopy, surgical; cholecystectomy	$1,940.66	$4,069.08	35	$67,632	$141,807	($74,175)	48%	52%
26055	Tendon sheath incision (eg, for trigger finger)	$682.56	$1,223.75	34	$23,207	$41,608	($18,400)	56%	44%
45331	Sigmoidoscopy, flexible; with biopsy, single or multiple	$342.25	$643.61	34	$11,637	$21,883	($10,246)	53%	47%
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure)	$0.00	$0.00	31	$0	$0	$0	n/a	n/a
49505	Repair initial inguinal hernia, age 5 years or older; reducible	$1,233.18	$2,639.02	28	$34,591	$74,025	($39,434)	47%	53%
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid	$756.07	$1,421.81	27	$20,565	$38,673	($18,108)	53%	47%
11042	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less	$149.82	$281.75	26	$3,820	$7,185	($3,364)	53%	47%
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2	$6,789.32	$9,176.63	22	$150,044	$202,804	($52,760)	74%	26%

Appendix B [3]

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MEDICARE CODES - ASC SAVINGS OPPORTUNITY - BASED ON 2017 EXPERIENCE DATA

CPT	2018 Full Description	2018 Medicare Area-Adj. ASC Rate	2018 Medicare Area-Adj HOPD OPPS Rate	2017 Estimated ASC Eligible Medicare Cases [1,2]	Total Projected Cost in ASC	Total Projected Cost in HOPD	Projected ASC Annual Savings based on 2018 ASC vs HOPD rates	ASC Rates as Percent of HOPD	Percent Savings in ASC
52235	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; MEDIUM bladder tumor(s) (2.0 to 5.0 cm)	$1,115.88	$2,444.67	22	$24,661	$54,027	($29,366)	46%	54%
55876	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple	$67.63	$1,075.75	21	$1,437	$22,860	($21,423)	6%	94%
36558	Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; age 5 years or older	$1,201.64	$2,259.72	20	$24,513	$46,098	($21,585)	53%	47%
63047	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar	$2,518.36	$5,082.33	20	$51,375	$103,680	($52,305)	50%	50%
19301	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);	$953.13	$2,472.84	19	$17,824	$46,242	($28,419)	39%	61%
33282	Implantation of patient-activated cardiac event recorder	$5,925.75	$6,681.95	19	$110,812	$124,952	($14,141)	89%	11%
31652	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), one or two mediastinal and/or hilar lymph node stations or structures	$1,062.65	$2,371.97	18	$18,968	$42,340	($23,371)	45%	55%

Appendix B [4]

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QUINCY MEDICAL GROUP ASC ELIGIBLE MEDICARE VOLUME

MEDICARE CODES - ASC SAVINGS OPPORTUNITY - BASED ON 2017 EXPERIENCE DATA

CPT	2018 Full Description	2018 Medicare Area-Adj. ASC Rate	2018 Medicare Area-Adj HOPD OPPS Rate	2017 Estimated ASC Eligible Medicare Cases [1,2]	Total Projected Cost in ASC	Total Projected Cost in HOPD	Projected ASC Annual Savings based on 2018 ASC vs HOPD rates	ASC Rates as Percent of HOPD	Percent Savings in ASC
43248	Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) through esophagus over guide wire	$358.41	$673.99	18	$6,398	$12,031	($5,633)	53%	47%
52351	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic	$721.43	$1,537.17	18	$12,878	$27,438	($14,561)	47%	53%
49650	Laparoscopy, surgical; repair initial inguinal hernia	$1,940.66	$4,069.08	17	$32,991	$69,174	($36,183)	48%	52%
14301	Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm	$1,306.61	$2,457.10	14	$17,770	$33,417	($15,647)	53%	47%
28299	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with double osteotomy, any method	$1,184.43	$2,397.95	14	$16,108	$32,612	($16,504)	49%	51%
36901	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report;	$295.30	$555.31	14	$4,016	$7,552	($3,536)	53%	47%
19303	Mastectomy, simple, complete	$1,893.40	$4,362.07	13	$24,141	$55,616	($31,476)	43%	57%
36830	Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); nonautogenous graft (eg, biological collagen, thermoplastic graft)	$2,055.95	$3,866.27	13	$26,213	$49,295	($23,082)	53%	47%

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QUINCY MEDICAL GROUP ASC ELIGIBLE MEDICARE VOLUME

MEDICARE CODES - ASC SAVINGS OPPORTUNITY - BASED ON 2017 EXPERIENCE DATA

CPT	2018 Full Description	2018 Medicare Area-Adj. ASC Rate	2018 Medicare Area-Adj HOPD OPPS Rate	2017 Estimated ASC Eligible Medicare Cases [1,2]	Total Projected Cost in ASC	Total Projected Cost in HOPD	Projected ASC Annual Savings based on 2018 ASC vs HOPD rates	ASC Rates as Percent of HOPD	Percent Savings in ASC
43249	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic balloon dilation of esophagus (less than 30 mm diameter)	$580.62	$1,293.96	13	$7,403	$16,498	($9,095)	45%	55%
52234	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 up to 2.0 cm)	$1,115.88	$2,444.67	13	$14,227	$31,170	($16,942)	46%	54%
29880	Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	$1,184.43	$2,397.95	12	$14,095	$28,536	($14,441)	49%	51%
31628	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe	$1,062.65	$2,371.97	11	$11,742	$26,210	($14,468)	45%	55%
49324	Laparoscopy, surgical; with insertion of tunneled intraperitoneal catheter	$1,940.66	$4,069.08	11	$21,444	$44,963	($23,519)	48%	52%
15275	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	$756.07	$1,421.81	10	$7,712	$14,502	($6,791)	53%	47%

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QUINCY MEDICAL GROUP ASC ELIGIBLE MEDICARE VOLUME

MEDICARE CODES - ASC SAVINGS OPPORTUNITY - BASED ON 2017 EXPERIENCE DATA

CPT	2018 Full Description	2018 Medicare Area-Adj. ASC Rate	2018 Medicare Area-Adj HOPD OPPS Rate	2017 Estimated ASC Eligible Medicare Cases [1,2]	Total Projected Cost in ASC	Total Projected Cost in HOPD	Projected ASC Annual Savings based on 2018 ASC vs HOPD rates	ASC Rates as Percent of HOPD	Percent Savings in ASC
36902	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	$2,336.20	$4,609.65	10	$23,829	$47,018	($23,189)	51%	49%
52224	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy	$721.43	$1,537.17	10	$7,359	$15,679	($8,321)	47%	53%
37226	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	$6,245.21	$9,527.94	9	$58,393	$89,086	($30,694)	66%	34%
43255	Esophagogastroduodenoscopy, flexible, transoral; with control of bleeding, any method	$580.62	$1,293.96	9	$5,429	$12,099	($6,670)	45%	55%
49585	Repair umbilical hernia, age 5 years or older; reducible	$1,233.18	$2,639.02	9	$11,530	$24,675	($13,145)	47%	53%
28820	Amputation, toe; metatarsophalangeal joint	$682.56	$1,223.75	9	$5,802	$10,402	($4,600)	56%	44%

Appendix B [7]

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QUINCY MEDICAL GROUP ASC ELIGIBLE MEDICARE VOLUME

MEDICARE CODES - ASC SAVINGS OPPORTUNITY - BASED ON 2017 EXPERIENCE DATA

CPT	2018 Full Description	2018 Medicare Area-Adj. ASC Rate	2018 Medicare Area-Adj HOPD OPPS Rate	2017 Estimated ASC Eligible Medicare Cases [1,2]	Total Projected Cost in ASC	Total Projected Cost in HOPD	Projected ASC Annual Savings based on 2018 ASC vs HOPD rates	ASC Rates as Percent of HOPD	Percent Savings in ASC
49560	Repair initial incisional or ventral hernia; reducible	$1,233.18	$2,639.02	9	$10,482	$22,432	($11,950)	47%	53%
52204	Cystourethroscopy, with biopsy(s)	$721.43	$1,537.17	9	$6,132	$13,066	($6,934)	47%	53%
52240	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; LARGE bladder tumor(s)	$1,625.91	$3,359.59	9	$13,820	$28,557	($14,736)	48%	52%
52352	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)	$1,625.91	$3,359.59	9	$13,820	$28,557	($14,736)	48%	52%
52354	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with biopsy and/or fulguration of ureteral or renal pelvic lesion	$1,625.91	$3,359.59	9	$13,820	$28,557	($14,736)	48%	52%
31535	Laryngoscopy, direct, operative, with biopsy;	$1,062.65	$2,371.97	8	$8,129	$18,146	($10,016)	45%	55%
36832	Revision, open, arteriovenous fistula; without thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)	$2,055.95	$3,866.27	8	$15,728	$29,577	($13,849)	53%	47%
37221	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	$5,924.16	$9,527.94	8	$45,320	$72,889	($27,569)	62%	38%
45382	Colonoscopy, flexible; with control of bleeding, any method	$451.39	$848.86	8	$3,453	$6,494	($3,041)	53%	47%
65756	Keratoplasty (corneal transplant); endothelial	$1,640.02	$3,273.22	8	$12,546	$25,040	($12,494)	50%	50%
33228	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; dual lead system	$7,224.94	$8,836.75	7	$49,130	$60,090	($10,960)	82%	18%

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QUINCY MEDICAL GROUP
QUINCY MEDICAL GROUP ASC ELIGIBLE MEDICARE VOLUME

MEDICARE CODES - ASC SAVINGS OPPORTUNITY - BASED ON 2017 EXPERIENCE DATA

CPT	2018 Full Description	2018 Medicare Area-Adj. ASC Rate	2018 Medicare Area-Adj HOPD OPPS Rate	2017 Estimated ASC Eligible Medicare Cases [1,2]	Total Projected Cost in ASC	Total Projected Cost in HOPD	Projected ASC Annual Savings based on 2018 ASC vs HOPD rates	ASC Rates as Percent of HOPD	Percent Savings in ASC
43246	Esophagogastroduodenoscopy, flexible, transoral; with directed placement of percutaneous gastrostomy tube	$580.62	$1,293.96	7	$3,948	$8,799	($4,851)	45%	55%
58558	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C	$1,038.27	$2,060.31	7	$7,060	$14,010	($6,950)	50%	50%
66180	Aqueous shunt to extraocular equatorial plate reservoir, external approach; with graft	$1,640.02	$3,273.22	7	$11,152	$22,258	($11,106)	50%	50%
28285	Correction, hammertoe (eg, interphalangeal fusion, partial or total phalangectomy)	$1,184.43	$2,397.95	6	$7,047	$14,268	($7,220)	49%	51%
37609	Ligation or biopsy, temporal artery	$502.38	$1,222.02	6	$2,989	$7,271	($4,282)	41%	59%
43247	Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body(s)	$358.41	$673.99	6	$2,133	$4,010	($1,878)	53%	47%
51102	Aspiration of bladder; with insertion of suprapubic catheter	$721.43	$1,537.17	6	$4,293	$9,146	($4,854)	47%	53%
52601	Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)	$1,625.91	$3,359.59	6	$9,674	$19,990	($10,315)	48%	52%
66183	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach	$1,640.02	$3,273.22	6	$9,758	$19,476	($9,718)	50%	50%
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)	$748.16	$1,642.03	6	$4,452	$9,770	($5,319)	46%	54%
10140	Incision and drainage of hematoma, seroma or fluid collection	$96.94	$1,222.02	5	$494	$6,232	($5,738)	8%	92%

QUINCY MEDICAL GROUP
QUINCY MEDICAL GROUP ASC ELIGIBLE MEDICARE VOLUME

MEDICARE CODES - ASC SAVINGS OPPORTUNITY - BASED ON 2017 EXPERIENCE DATA

CPT	2018 Full Description	2018 Medicare Area-Adj. ASC Rate	2018 Medicare Area-Adj HOPD OPPS Rate	2017 Estimated ASC Eligible Medicare Cases [1,2]	Total Projected Cost in ASC	Total Projected Cost in HOPD	Projected ASC Annual Savings based on 2018 ASC vs HOPD rates	ASC Rates as Percent of HOPD	Percent Savings in ASC
31653	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), 3 or more mediastinal and/or hilar lymph node stations or structures	$1,062.65	$2,371.97	5	$5,420	$12,097	($6,678)	45%	55%
36818	Arteriovenous anastomosis, open; by upper arm cephalic vein transposition	$2,055.95	$3,866.27	5	$10,485	$19,718	($9,233)	53%	47%
43205	Esophagoscopy, flexible, transoral; with band ligation of esophageal varices	$580.62	$1,293.96	5	$2,961	$6,599	($3,638)	45%	55%
58260	Vaginal hysterectomy, for uterus 250 g or less;	$1,702.00	$3,727.44	5	$8,680	$19,010	($10,330)	46%	54%
15822	Blepharoplasty, upper eyelid;	$756.07	$1,421.81	4	$3,213	$6,043	($2,829)	53%	47%
36906	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit	$6,407.90	$14,522.80	4	$27,234	$61,722	($34,488)	44%	56%

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QUINCY MEDICAL GROUP
QUINCY MEDICAL GROUP ASC ELIGIBLE MEDICARE VOLUME

MEDICARE CODES - ASC SAVINGS OPPORTUNITY - BASED ON 2017 EXPERIENCE DATA

CPT	2018 Full Description	2018 Medicare Area-Adj. ASC Rate	2018 Medicare Area-Adj HOPD OPPS Rate	2017 Estimated ASC Eligible Medicare Cases [1,2]	Total Projected Cost in ASC	Total Projected Cost in HOPD	Projected ASC Annual Savings based on 2018 ASC vs HOPD rates	ASC Rates as Percent of HOPD	Percent Savings in ASC
37193	Retrieval (removal) of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed	n/a	$2,259.72	4	$0	$9,604	($9,604)	n/a	n/a
37236	Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; initial artery	$4,145.84	$9,527.94	4	$17,620	$40,494	($22,874)	44%	56%
43251	Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	$580.62	$1,293.96	4	$2,468	$5,499	($3,032)	45%	55%
43264	Endoscopic retrograde cholangiopancreatography (ERCP); with removal of calculi/debris from biliary/pancreatic duct(s)	$1,121.58	$2,486.98	4	$4,767	$10,570	($5,803)	45%	55%
51040	Cystostomy, cystotomy with drainage	$721.43	$1,537.17	4	$3,066	$6,533	($3,467)	47%	53%
52000	Cystourethroscopy (separate procedure)	$272.65	$512.73	4	$1,159	$2,179	($1,020)	53%	47%
52500	Transurethral resection of bladder neck (separate procedure)	$1,115.88	$2,444.67	4	$4,742	$10,390	($5,647)	46%	54%
55040	Excision of hydrocele; unilateral	$1,233.18	$2,639.02	4	$5,241	$11,216	($5,975)	47%	53%
57288	Sling operation for stress incontinence (eg, fascia or synthetic)	$1,702.00	$3,727.44	4	$7,234	$15,842	($8,608)	46%	54%

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QUINCY MEDICAL GROUP
QUINCY MEDICAL GROUP ASC ELIGIBLE MEDICARE VOLUME

MEDICARE CODES - ASC SAVINGS OPPORTUNITY - BASED ON 2017 EXPERIENCE DATA

CPT	2018 Full Description	2018 Medicare Area-Adj. ASC Rate	2018 Medicare Area-Adj HOPD OPPS Rate	2017 Estimated ASC Eligible Medicare Cases [1,2]	Total Projected Cost in ASC	Total Projected Cost in HOPD	Projected ASC Annual Savings based on 2018 ASC vs HOPD rates	ASC Rates as Percent of HOPD	Percent Savings in ASC
63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar	$2,518.36	$5,082.33	4	$10,703	$21,600	($10,897)	50%	50%
64718	Neuroplasty and/or transposition; ulnar nerve at elbow	$726.82	$1,459.95	4	$3,089	$6,205	($3,116)	50%	50%
66170	Fistulization of sclera for glaucoma; trabeculectomy ab externo in absence of previous surgery	$917.95	$1,741.51	4	$3,901	$7,401	($3,500)	53%	47%
66840	Removal of lens material; aspiration technique, 1 or more stages	$917.95	$1,741.51	4	$3,901	$7,401	($3,500)	53%	47%
11604	Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 3.1 to 4.0 cm	$276.15	$519.30	3	$939	$1,766	($827)	53%	47%
19302	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy	$1,893.40	$4,362.07	3	$6,438	$14,831	($8,393)	43%	57%
25447	Arthroplasty, interposition, intercarpal or carpometacarpal joints	$1,184.43	$2,397.95	3	$4,027	$8,153	($4,126)	49%	51%
31570	Laryngoscopy, direct, with injection into vocal cord(s), therapeutic;	$1,062.65	$2,371.97	3	$3,613	$8,065	($4,452)	45%	55%
31622	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)	$544.34	$1,199.96	3	$1,851	$4,080	($2,229)	45%	55%
33249	Insertion or replacement of permanent implantable defibrillator system, with transvenous lead(s), single or dual chamber	$25,300.77	$28,067.79	3	$86,023	$95,430	($9,408)	90%	10%
33284	Removal of an implantable, patient-activated cardiac event recorder	$276.15	$519.30	3	$939	$1,766	($827)	53%	47%

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QUINCY MEDICAL GROUP
QUINCY MEDICAL GROUP ASC ELIGIBLE MEDICARE VOLUME

MEDICARE CODES - ASC SAVINGS OPPORTUNITY - BASED ON 2017 EXPERIENCE DATA

CPT	2018 Full Description	2018 Medicare Area-Adj. ASC Rate	2018 Medicare Area-Adj HOPD OPPS Rate	2017 Estimated ASC Eligible Medicare Cases [1,2]	Total Projected Cost in ASC	Total Projected Cost in HOPD	Projected ASC Annual Savings based on 2018 ASC vs HOPD rates	ASC Rates as Percent of HOPD	Percent Savings in ASC
36903	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis segment	$4,145.84	$9,527.94	3	$14,096	$32,395	($18,299)	44%	56%
36905	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	$4,145.84	$9,527.94	3	$14,096	$32,395	($18,299)	44%	56%

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QUINCY MEDICAL GROUP
QUINCY MEDICAL GROUP ASC ELIGIBLE MEDICARE VOLUME

MEDICARE CODES - ASC SAVINGS OPPORTUNITY - BASED ON 2017 EXPERIENCE DATA

CPT	2018 Full Description	2018 Medicare Area-Adj. ASC Rate	2018 Medicare Area-Adj HOPD OPPS Rate	2017 Estimated ASC Eligible Medicare Cases [1,2]	Total Projected Cost in ASC	Total Projected Cost in HOPD	Projected ASC Annual Savings based on 2018 ASC vs HOPD rates	ASC Rates as Percent of HOPD	Percent Savings in ASC
38500	Biopsy or excision of lymph node(s); open, superficial	$953.13	$2,472.84	3	$3,241	$8,408	($5,167)	39%	61%
43245	Esophagogastroduodenoscopy, flexible, transoral; with dilation of gastric/duodenal stricture(s) (eg, balloon, bougie)	$580.62	$1,293.96	3	$1,974	$4,399	($2,425)	45%	55%
43760	Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance	$110.65	$208.07	3	$376	$707	($331)	53%	47%
47563	Laparoscopy, surgical; cholecystectomy with cholangiography	$1,940.66	$4,069.08	3	$6,598	$13,835	($7,237)	48%	52%
52005	Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;	$721.43	$1,537.17	3	$2,453	$5,226	($2,774)	47%	53%
52281	Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female	$721.43	$1,537.17	3	$2,453	$5,226	($2,774)	47%	53%
52287	Cystourethroscopy, with injection(s) for chemodenervation of the bladder	$721.43	$1,537.17	3	$2,453	$5,226	($2,774)	47%	53%
52318	Litholapaxy: crushing or fragmentation of calculus by any means in bladder and removal of fragments; complicated or large (over 2.5 cm)	$1,625.91	$3,359.59	3	$5,528	$11,423	($5,895)	48%	52%
55700	Biopsy, prostate; needle or punch, single or multiple, any approach	$721.43	$1,537.17	3	$2,453	$5,226	($2,774)	47%	53%
55875	Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy	$1,625.91	$3,359.59	3	$5,528	$11,423	($5,895)	48%	52%

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QUINCY MEDICAL GROUP
QUINCY MEDICAL GROUP ASC ELIGIBLE MEDICARE VOLUME

MEDICARE CODES - ASC SAVINGS OPPORTUNITY - BASED ON 2017 EXPERIENCE DATA

CPT	2018 Full Description	2018 Medicare Area-Adj. ASC Rate	2018 Medicare Area-Adj HOPD OPPS Rate	2017 Estimated ASC Eligible Medicare Cases [1,2]	Total Projected Cost in ASC	Total Projected Cost in HOPD	Projected ASC Annual Savings based on 2018 ASC vs HOPD rates	ASC Rates as Percent of HOPD	Percent Savings in ASC
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)	$1,940.66	$4,069.08	3	$6,598	$13,835	($7,237)	48%	52%
60220	Total thyroid lobectomy, unilateral; with or without isthmusectomy	$1,940.66	$4,069.08	3	$6,598	$13,835	($7,237)	48%	52%
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver	$1,388.02	$2,610.22	3	$4,719	$8,875	($4,155)	53%	47%
66172	Fistulization of sclera for glaucoma; trabeculectomy ab externo with scarring from previous ocular surgery or trauma (includes injection of antifibrotic agents)	$917.95	$1,741.51	3	$3,121	$5,921	($2,800)	53%	47%
67916	Repair of ectropion; excision tarsal wedge	$748.16	$1,642.03	3	$2,544	$5,583	($3,039)	46%	54%
67924	Repair of entropion; extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation)	$748.16	$1,642.03	3	$2,544	$5,583	($3,039)	46%	54%
69436	Tympanostomy (requiring insertion of ventilating tube), general anesthesia	$548.66	$1,031.78	3	$1,865	$3,508	($1,643)	53%	47%
11044	Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less	$502.38	$1,222.02	3	$1,281	$3,116	($1,835)	41%	59%
15271	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	$756.07	$1,421.81	3	$1,928	$3,626	($1,698)	53%	47%
15630	Delay of flap or sectioning of flap (division and inset); at eyelids, nose, ears, or lips	$756.07	$1,421.81	3	$1,928	$3,626	($1,698)	53%	47%
15734	Muscle, myocutaneous, or fasciocutaneous flap; trunk	$1,306.61	$2,457.10	3	$3,332	$6,266	($2,934)	53%	47%
19366	Breast reconstruction with other technique	$1,893.40	$4,362.07	3	$4,828	$11,123	($6,295)	43%	57%

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QUINCY MEDICAL GROUP
QUINCY MEDICAL GROUP ASC ELIGIBLE MEDICARE VOLUME

MEDICARE CODES - ASC SAVINGS OPPORTUNITY - BASED ON 2017 EXPERIENCE DATA

CPT	2018 Full Description	2018 Medicare Area-Adj. ASC Rate	2018 Medicare Area-Adj HOPD OPPS Rate	2017 Estimated ASC Eligible Medicare Cases [1,2]	Total Projected Cost in ASC	Total Projected Cost in HOPD	Projected ASC Annual Savings based on 2018 ASC vs HOPD rates	ASC Rates as Percent of HOPD	Percent Savings in ASC
20680	Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)	$983.49	$2,107.54	3	$2,508	$5,374	($2,866)	47%	53%
21552	Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; 3 cm or greater	$983.49	$2,107.54	3	$2,508	$5,374	($2,866)	47%	53%
28008	Fasciotomy, foot and/or toe	$1,184.43	$2,397.95	3	$3,020	$6,115	($3,094)	49%	51%
28090	Excision of lesion, tendon, tendon sheath, or capsule (including synovectomy) (eg, cyst or ganglion); foot	$682.56	$1,223.75	3	$1,741	$3,121	($1,380)	56%	44%
28292	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with resection of proximal phalanx base, when performed, any method	$1,184.43	$2,397.95	3	$3,020	$6,115	($3,094)	49%	51%
28296	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with distal metatarsal osteotomy, any method	$1,184.43	$2,397.95	3	$3,020	$6,115	($3,094)	49%	51%
28810	Amputation, metatarsal, with toe, single	$1,184.43	$2,397.95	3	$3,020	$6,115	($3,094)	49%	51%
29875	Arthroscopy, knee, surgical; synovectomy, limited (eg, plica or shelf resection) (separate procedure)	$1,184.43	$2,397.95	3	$3,020	$6,115	($3,094)	49%	51%
33263	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; dual lead system	$18,058.66	$20,043.63	3	$46,050	$51,111	($5,062)	90%	10%
36247	Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family	$0.00	$0.00	3	$0	$0	$0	n/a	n/a

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QUINCY MEDICAL GROUP
QUINCY MEDICAL GROUP ASC ELIGIBLE MEDICARE VOLUME

MEDICARE CODES - ASC SAVINGS OPPORTUNITY - BASED ON 2017 EXPERIENCE DATA

CPT	2018 Full Description	2018 Medicare Area-Adj. ASC Rate	2018 Medicare Area-Adj HOPD OPPS Rate	2017 Estimated ASC Eligible Medicare Cases [1,2]	Total Projected Cost in ASC	Total Projected Cost in HOPD	Projected ASC Annual Savings based on 2018 ASC vs HOPD rates	ASC Rates as Percent of HOPD	Percent Savings in ASC
36819	Arteriovenous anastomosis, open; by upper arm basilic vein transposition	$2,055.95	$3,866.27	3	$5,243	$9,859	($4,616)	53%	47%
36821	Arteriovenous anastomosis, open; direct, any site (eg, Cimino type) (separate procedure)	$1,201.64	$2,259.72	3	$3,064	$5,762	($2,698)	53%	47%
37225	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed	$6,499.91	$9,527.94	3	$16,575	$24,296	($7,721)	68%	32%
38510	Biopsy or excision of lymph node(s); open, deep cervical node(s)	$953.13	$2,472.84	3	$2,430	$6,306	($3,875)	39%	61%
38525	Biopsy or excision of lymph node(s); open, deep axillary node(s)	$953.13	$2,472.84	3	$2,430	$6,306	($3,875)	39%	61%
44360	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	$580.62	$1,293.96	3	$1,481	$3,300	($1,819)	45%	55%
44386	Endoscopic evaluation of small intestinal pouch (eg, Kock pouch, ileal reservoir [S or J]); with biopsy, single or multiple	$342.25	$643.61	3	$873	$1,641	($768)	53%	47%
44389	Colonoscopy through stoma; with biopsy, single or multiple	$451.39	$848.86	3	$1,151	$2,165	($1,014)	53%	47%
44970	Laparoscopy, surgical, appendectomy	n/a	$4,069.08	3	$0	$10,376	($10,376)	n/a	n/a
49422	Removal of tunneled intraperitoneal catheter	$1,201.64	$2,259.72	3	$3,064	$5,762	($2,698)	53%	47%
49561	Repair initial incisional or ventral hernia; incarcerated or strangulated	$1,233.18	$2,639.02	3	$3,145	$6,730	($3,585)	47%	53%
49565	Repair recurrent incisional or ventral hernia; reducible	$1,940.66	$4,069.08	3	$4,949	$10,376	($5,427)	48%	52%

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QUINCY MEDICAL GROUP
QUINCY MEDICAL GROUP ASC ELIGIBLE MEDICARE VOLUME

MEDICARE CODES - ASC SAVINGS OPPORTUNITY - BASED ON 2017 EXPERIENCE DATA

CPT	2018 Full Description	2018 Medicare Area-Adj. ASC Rate	2018 Medicare Area-Adj HOPD OPPS Rate	2017 Estimated ASC Eligible Medicare Cases [1,2]	Total Projected Cost in ASC	Total Projected Cost in HOPD	Projected ASC Annual Savings based on 2018 ASC vs HOPD rates	ASC Rates as Percent of HOPD	Percent Savings in ASC
49654	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible	$3,117.03	$6,885.40	3	$7,948	$17,558	($9,609)	45%	55%
50580	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus	$1,625.91	$3,359.59	3	$4,146	$8,567	($4,421)	48%	52%
51700	Bladder irrigation, simple, lavage and/or instillation	$48.31	$208.07	3	$123	$531	($407)	23%	77%
51715	Endoscopic injection of implant material into the submucosal tissues of the urethra and/or bladder neck	$1,115.88	$2,444.67	3	$2,845	$6,234	($3,388)	46%	54%
52276	Cystourethroscopy with direct vision internal urethrotomy	$721.43	$1,537.17	3	$1,840	$3,920	($2,080)	47%	53%
52310	Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); simple	$721.43	$1,537.17	3	$1,840	$3,920	($2,080)	47%	53%
54161	Circumcision, surgical excision other than clamp, device, or dorsal slit; older than 28 days of age	$721.43	$1,537.17	3	$1,840	$3,920	($2,080)	47%	53%
66825	Repositioning of intraocular lens prosthesis, requiring an incision (separate procedure)	$917.95	$1,741.51	3	$2,341	$4,441	($2,100)	53%	47%
66985	Insertion of intraocular lens prosthesis (secondary implant), not associated with concurrent cataract removal	$917.95	$1,741.51	3	$2,341	$4,441	($2,100)	53%	47%
67917	Repair of ectropion; extensive (eg, tarsal strip operations)	$748.16	$1,642.03	3	$1,908	$4,187	($2,279)	46%	54%
67923	Repair of entropion; excision tarsal wedge	$748.16	$1,642.03	3	$1,908	$4,187	($2,279)	46%	54%
10121	Incision and removal of foreign body, subcutaneous tissues; complicated	$502.38	$1,222.02	2	$854	$2,077	($1,223)	41%	59%

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QUINCY MEDICAL GROUP
QUINCY MEDICAL GROUP ASC ELIGIBLE MEDICARE VOLUME

MEDICARE CODES - ASC SAVINGS OPPORTUNITY - BASED ON 2017 EXPERIENCE DATA

CPT	2018 Full Description	2018 Medicare Area-Adj. ASC Rate	2018 Medicare Area-Adj HOPD OPPS Rate	2017 Estimated ASC Eligible Medicare Cases [1,2]	Total Projected Cost in ASC	Total Projected Cost in HOPD	Projected ASC Annual Savings based on 2018 ASC vs HOPD rates	ASC Rates as Percent of HOPD	Percent Savings in ASC
11043	Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less	$235.34	$442.56	2	$400	$752	($352)	53%	47%
11406	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm	$502.38	$1,222.02	2	$854	$2,077	($1,223)	41%	59%
13132	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm	$235.34	$442.56	2	$400	$752	($352)	53%	47%
14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less	$756.07	$1,421.81	2	$1,285	$2,417	($1,132)	53%	47%
15260	Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less	$756.07	$1,421.81	2	$1,285	$2,417	($1,132)	53%	47%
19125	Excision of breast lesion identified by preoperative placement of radiological marker, open; single lesion	$953.13	$2,472.84	2	$1,620	$4,204	($2,584)	39%	61%
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction	$1,893.40	$4,362.07	2	$3,219	$7,416	($4,197)	43%	57%
19380	Revision of reconstructed breast	$1,893.40	$4,362.07	2	$3,219	$7,416	($4,197)	43%	57%
21235	Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)	$1,982.65	$3,933.20	2	$3,371	$6,686	($3,316)	50%	50%
23075	Excision, tumor, soft tissue of shoulder area, subcutaneous; less than 3 cm	$502.38	$1,222.02	2	$854	$2,077	($1,223)	41%	59%
25000	Incision, extensor tendon sheath, wrist (eg, de Quervains disease)	$682.56	$1,223.75	2	$1,160	$2,080	($920)	56%	44%
25111	Excision of ganglion, wrist (dorsal or volar); primary	$682.56	$1,223.75	2	$1,160	$2,080	($920)	56%	44%

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QUINCY MEDICAL GROUP
QUINCY MEDICAL GROUP ASC ELIGIBLE MEDICARE VOLUME

MEDICARE CODES - ASC SAVINGS OPPORTUNITY - BASED ON 2017 EXPERIENCE DATA

CPT	2018 Full Description	2018 Medicare Area-Adj. ASC Rate	2018 Medicare Area-Adj HOPD OPPS Rate	2017 Estimated ASC Eligible Medicare Cases [1,2]	Total Projected Cost in ASC	Total Projected Cost in HOPD	Projected ASC Annual Savings based on 2018 ASC vs HOPD rates	ASC Rates as Percent of HOPD	Percent Savings in ASC
26160	Excision of lesion of tendon sheath or joint capsule (eg, cyst, mucous cyst, or ganglion), hand or finger	$682.56	$1,223.75	2	$1,160	$2,080	($920)	56%	44%
26746	Open treatment of articular fracture, involving metacarpophalangeal or interphalangeal joint, includes internal fixation, when performed, each	$1,184.43	$2,397.95	2	$2,014	$4,077	($2,063)	49%	51%
26951	Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure	$1,184.43	$2,397.95	2	$2,014	$4,077	($2,063)	49%	51%
27570	Manipulation of knee joint under general anesthesia (includes application of traction or other fixation devices)	$682.56	$1,223.75	2	$1,160	$2,080	($920)	56%	44%
27650	Repair, primary, open or percutaneous, ruptured Achilles tendon;	$1,184.43	$2,397.95	2	$2,014	$4,077	($2,063)	49%	51%
28122	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); tarsal or metatarsal bone, except talus or calcaneus	$1,184.43	$2,397.95	2	$2,014	$4,077	($2,063)	49%	51%
29806	Arthroscopy, shoulder, surgical; capsulorrhaphy	$2,518.36	$5,082.33	2	$4,281	$8,640	($4,359)	50%	50%
33207	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); ventricular	$7,247.83	$8,836.75	2	$12,321	$15,022	($2,701)	82%	18%

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QUINCY MEDICAL GROUP
QUINCY MEDICAL GROUP ASC ELIGIBLE MEDICARE VOLUME

MEDICARE CODES - ASC SAVINGS OPPORTUNITY - BASED ON 2017 EXPERIENCE DATA

CPT	2018 Full Description	2018 Medicare Area-Adj. ASC Rate	2018 Medicare Area-Adj HOPD OPPS Rate	2017 Estimated ASC Eligible Medicare Cases [1,2]	Total Projected Cost in ASC	Total Projected Cost in HOPD	Projected ASC Annual Savings based on 2018 ASC vs HOPD rates	ASC Rates as Percent of HOPD	Percent Savings in ASC
33225	Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of implantable defibrillator or pacemaker pulse generator (eg, for upgrade to dual chamber system) (List separately in addition to code for primary procedure)	$0.00	$0.00	2	$0	$0	$0	n/a	n/a
36245	Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family	$0.00	$0.00	2	$0	$0	$0	n/a	n/a
36252	Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral	$0.00	$2,259.72	2	$0	$3,842	($3,842)	n/a	n/a
36582	Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous port, through same venous access	$1,201.64	$2,259.72	2	$2,043	$3,842	($1,799)	53%	47%

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QUINCY MEDICAL GROUP
QUINCY MEDICAL GROUP ASC ELIGIBLE MEDICARE VOLUME

MEDICARE CODES - ASC SAVINGS OPPORTUNITY - BASED ON 2017 EXPERIENCE DATA

CPT	2018 Full Description	2018 Medicare Area-Adj. ASC Rate	2018 Medicare Area-Adj HOPD OPPS Rate	2017 Estimated ASC Eligible Medicare Cases [1,2]	Total Projected Cost in ASC	Total Projected Cost in HOPD	Projected ASC Annual Savings based on 2018 ASC vs HOPD rates	ASC Rates as Percent of HOPD	Percent Savings in ASC
36904	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s);	$2,336.20	$4,609.65	2	$3,972	$7,836	($3,865)	51%	49%
37229	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed	$9,464.77	$14,522.80	2	$16,090	$24,689	($8,599)	65%	35%
43236	Esophagogastroduodenoscopy, flexible, transoral; with directed submucosal injection(s), any substance	$358.41	$673.99	2	$609	$1,146	($536)	53%	47%
44366	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)	$580.62	$1,293.96	2	$987	$2,200	($1,213)	45%	55%
44382	Ileoscopy, through stoma; with biopsy, single or multiple	$358.41	$673.99	2	$609	$1,146	($536)	53%	47%
44394	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	$451.39	$848.86	2	$767	$1,443	($676)	53%	47%
45338	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	$451.39	$848.86	2	$767	$1,443	($676)	53%	47%

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QUINCY MEDICAL GROUP
QUINCY MEDICAL GROUP ASC ELIGIBLE MEDICARE VOLUME

MEDICARE CODES - ASC SAVINGS OPPORTUNITY - BASED ON 2017 EXPERIENCE DATA

CPT	2018 Full Description	2018 Medicare Area-Adj. ASC Rate	2018 Medicare Area-Adj HOPD OPPS Rate	2017 Estimated ASC Eligible Medicare Cases [1,2]	Total Projected Cost in ASC	Total Projected Cost in HOPD	Projected ASC Annual Savings based on 2018 ASC vs HOPD rates	ASC Rates as Percent of HOPD	Percent Savings in ASC
45340	Sigmoidoscopy, flexible; with transendoscopic balloon dilation	$451.39	$848.86	2	$767	$1,443	($676)	53%	47%
49325	Laparoscopy, surgical; with revision of previously placed intraperitoneal cannula or catheter, with removal of intraluminal obstructive material if performed	$1,940.66	$4,069.08	2	$3,299	$6,917	($3,618)	48%	52%
49507	Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated	$1,233.18	$2,639.02	2	$2,096	$4,486	($2,390)	47%	53%
49651	Laparoscopy, surgical; repair recurrent inguinal hernia	$1,940.66	$4,069.08	2	$3,299	$6,917	($3,618)	48%	52%
49652	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible	$1,940.66	$4,069.08	2	$3,299	$6,917	($3,618)	48%	52%
49653	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated	$1,940.66	$4,069.08	2	$3,299	$6,917	($3,618)	48%	52%
50590	Lithotripsy, extracorporeal shock wave	$1,625.91	$3,359.59	2	$2,764	$5,711	($2,947)	48%	52%
51703	Insertion of temporary indwelling bladder catheter; complicated (eg, altered anatomy, fractured catheter/balloon)	$65.71	$123.58	2	$112	$210	($98)	53%	47%
52640	Transurethral resection; of postoperative bladder neck contracture	$1,115.88	$2,444.67	2	$1,897	$4,156	($2,259)	46%	54%
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach	$1,115.88	$2,444.67	2	$1,897	$4,156	($2,259)	46%	54%

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QUINCY MEDICAL GROUP
QUINCY MEDICAL GROUP ASC ELIGIBLE MEDICARE VOLUME

MEDICARE CODES - ASC SAVINGS OPPORTUNITY - BASED ON 2017 EXPERIENCE DATA

CPT	2018 Full Description	2018 Medicare Area-Adj. ASC Rate	2018 Medicare Area-Adj HOPD OPPS Rate	2017 Estimated ASC Eligible Medicare Cases [1,2]	Total Projected Cost in ASC	Total Projected Cost in HOPD	Projected ASC Annual Savings based on 2018 ASC vs HOPD rates	ASC Rates as Percent of HOPD	Percent Savings in ASC
57265	Combined anteroposterior colporrhaphy, including cystourethroscopy, when performed; with enterocele repair	$1,702.00	$3,727.44	2	$2,893	$6,337	($3,443)	46%	54%
58270	Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele	n/a	$3,727.44	2	$0	$6,337	($6,337)	n/a	n/a
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	$3,117.03	$6,885.40	2	$5,299	$11,705	($6,406)	45%	55%
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural	$13,886.81	$16,651.77	2	$23,608	$28,308	($4,700)	83%	17%
65755	Keratoplasty (corneal transplant); penetrating (in pseudophakia)	$1,640.02	$3,273.22	2	$2,788	$5,564	($2,776)	50%	50%
66710	Ciliary body destruction; cyclophotocoagulation, transscleral	$748.16	$1,642.03	2	$1,272	$2,791	($1,520)	46%	54%
67010	Removal of vitreous, anterior approach (open sky technique or limbal incision); subtotal removal with mechanical vitrectomy	$917.95	$1,741.51	2	$1,561	$2,961	($1,400)	53%	47%
10061	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple	$104.27	$281.75	1	$89	$239	($151)	37%	63%
11045	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	$0.00	$0.00	1	$0	$0	$0	n/a	n/a
11100	Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion	$69.29	$281.75	1	$59	$239	($181)	25%	75%

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QUINCY MEDICAL GROUP
QUINCY MEDICAL GROUP ASC ELIGIBLE MEDICARE VOLUME

MEDICARE CODES - ASC SAVINGS OPPORTUNITY - BASED ON 2017 EXPERIENCE DATA

CPT	2018 Full Description	2018 Medicare Area-Adj. ASC Rate	2018 Medicare Area-Adj HOPD OPPS Rate	2017 Estimated ASC Eligible Medicare Cases [1,2]	Total Projected Cost in ASC	Total Projected Cost in HOPD	Projected ASC Annual Savings based on 2018 ASC vs HOPD rates	ASC Rates as Percent of HOPD	Percent Savings in ASC
11606	Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter over 4.0 cm	$502.38	$1,222.02	1	$427	$1,039	($612)	41%	59%
11624	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm	$502.38	$1,222.02	1	$427	$1,039	($612)	41%	59%
11642	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 1.1 to 2.0 cm	$157.24	$519.30	1	$134	$441	($308)	30%	70%
11643	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 2.1 to 3.0 cm	$172.24	$1,222.02	1	$146	$1,039	($892)	14%	86%
11644	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 3.1 to 4.0 cm	$502.38	$1,222.02	1	$427	$1,039	($612)	41%	59%
11970	Replacement of tissue expander with permanent prosthesis	$2,518.36	$5,082.33	1	$2,141	$4,320	($2,179)	50%	50%
12052	Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm	$149.82	$281.75	1	$127	$239	($112)	53%	47%
13121	Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm	$235.34	$442.56	1	$200	$376	($176)	53%	47%
13131	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm	$149.82	$281.75	1	$127	$239	($112)	53%	47%
13152	Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm	$235.34	$442.56	1	$200	$376	($176)	53%	47%
14021	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm	$756.07	$1,421.81	1	$643	$1,209	($566)	53%	47%

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QUINCY MEDICAL GROUP
QUINCY MEDICAL GROUP ASC ELIGIBLE MEDICARE VOLUME

MEDICARE CODES - ASC SAVINGS OPPORTUNITY - BASED ON 2017 EXPERIENCE DATA

CPT	2018 Full Description	2018 Medicare Area-Adj. ASC Rate	2018 Medicare Area-Adj HOPD OPPS Rate	2017 Estimated ASC Eligible Medicare Cases [1,2]	Total Projected Cost in ASC	Total Projected Cost in HOPD	Projected ASC Annual Savings based on 2018 ASC vs HOPD rates	ASC Rates as Percent of HOPD	Percent Savings in ASC
15100	Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)	$756.07	$1,421.81	1	$643	$1,209	($566)	53%	47%
15273	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	$1,306.61	$2,457.10	1	$1,111	$2,089	($978)	53%	47%
15740	Flap; island pedicle requiring identification and dissection of an anatomically named axial vessel	$756.07	$1,421.81	1	$643	$1,209	($566)	53%	47%
15820	Blepharoplasty, lower eyelid;	$756.07	$1,421.81	1	$643	$1,209	($566)	53%	47%
19020	Mastotomy with exploration or drainage of abscess, deep	$502.38	$1,222.02	1	$427	$1,039	($612)	41%	59%
19120	Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion (except 19300), open, male or female, 1 or more lesions	$953.13	$2,472.84	1	$810	$2,102	($1,292)	39%	61%
19318	Reduction mammaplasty	$1,893.40	$4,362.07	1	$1,609	$3,708	($2,098)	43%	57%
19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction	$2,270.64	$6,697.12	1	$1,930	$5,693	($3,763)	34%	66%
19357	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion	$2,859.98	$10,323.95	1	$2,431	$8,775	($6,344)	28%	72%
20525	Removal of foreign body in muscle or tendon sheath; deep or complicated	$983.49	$2,107.54	1	$836	$1,791	($955)	47%	53%
20610	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance	$26.98	$221.83	1	$23	$189	($166)	12%	88%

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QUINCY MEDICAL GROUP
QUINCY MEDICAL GROUP ASC ELIGIBLE MEDICARE VOLUME

MEDICARE CODES - ASC SAVINGS OPPORTUNITY - BASED ON 2017 EXPERIENCE DATA

CPT	2018 Full Description	2018 Medicare Area-Adj. ASC Rate	2018 Medicare Area-Adj HOPD OPPS Rate	2017 Estimated ASC Eligible Medicare Cases [1,2]	Total Projected Cost in ASC	Total Projected Cost in HOPD	Projected ASC Annual Savings based on 2018 ASC vs HOPD rates	ASC Rates as Percent of HOPD	Percent Savings in ASC
20926	Tissue grafts, other (eg, paratenon, fat, dermis)	$1,306.61	$2,457.10	1	$1,111	$2,089	($978)	53%	47%
21315	Closed treatment of nasal bone fracture; without stabilization	$548.66	$1,031.78	1	$466	$877	($411)	53%	47%
21556	Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); less than 5 cm	$983.49	$2,107.54	1	$836	$1,791	($955)	47%	53%
21925	Biopsy, soft tissue of back or flank; deep	$502.38	$1,222.02	1	$427	$1,039	($612)	41%	59%
22612	Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)	$4,690.90	$9,176.63	1	$3,987	$7,800	($3,813)	51%	49%
22903	Excision, tumor, soft tissue of abdominal wall, subcutaneous; 3 cm or greater	$983.49	$2,107.54	1	$836	$1,791	($955)	47%	53%
24120	Excision or curettage of bone cyst or benign tumor of head or neck of radius or olecranon process;	$1,184.43	$2,397.95	1	$1,007	$2,038	($1,031)	49%	51%
24341	Repair, tendon or muscle, upper arm or elbow, each tendon or muscle, primary or secondary (excludes rotator cuff)	$2,518.36	$5,082.33	1	$2,141	$4,320	($2,179)	50%	50%
24342	Reinsertion of ruptured biceps or triceps tendon, distal, with or without tendon graft	$2,518.36	$5,082.33	1	$2,141	$4,320	($2,179)	50%	50%
25073	Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); 3 cm or greater	$983.49	$2,107.54	1	$836	$1,791	($955)	47%	53%
25076	Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); less than 3 cm	$502.38	$1,222.02	1	$427	$1,039	($612)	41%	59%
25118	Synovectomy, extensor tendon sheath, wrist, single compartment;	$682.56	$1,223.75	1	$580	$1,040	($460)	56%	44%
25210	Carpectomy; 1 bone	$1,184.43	$2,397.95	1	$1,007	$2,038	($1,031)	49%	51%

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QUINCY MEDICAL GROUP
QUINCY MEDICAL GROUP ASC ELIGIBLE MEDICARE VOLUME

MEDICARE CODES - ASC SAVINGS OPPORTUNITY - BASED ON 2017 EXPERIENCE DATA

CPT	2018 Full Description	2018 Medicare Area-Adj. ASC Rate	2018 Medicare Area-Adj HOPD OPPS Rate	2017 Estimated ASC Eligible Medicare Cases [1,2]	Total Projected Cost in ASC	Total Projected Cost in HOPD	Projected ASC Annual Savings based on 2018 ASC vs HOPD rates	ASC Rates as Percent of HOPD	Percent Savings in ASC
25400	Repair of nonunion or malunion, radius OR ulna; without graft (eg, compression technique)	$2,518.36	$5,082.33	1	$2,141	$4,320	($2,179)	50%	50%
25605	Closed treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, includes closed treatment of fracture of ulnar styloid, when performed; with manipulation	$682.56	$1,223.75	1	$580	$1,040	($460)	56%	44%
25608	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments	$3,529.34	$5,082.33	1	$3,000	$4,320	($1,320)	69%	31%
25609	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments	$3,568.02	$5,082.33	1	$3,033	$4,320	($1,287)	70%	30%
26034	Incision, bone cortex, hand or finger (eg, osteomyelitis or bone abscess)	$682.56	$1,223.75	1	$580	$1,040	($460)	56%	44%
26121	Fasciectomy, palm only, with or without Z-plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft)	$1,184.43	$2,397.95	1	$1,007	$2,038	($1,031)	49%	51%
26123	Fasciectomy, partial palmar with release of single digit including proximal interphalangeal joint, with or without Z-plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft);	$1,184.43	$2,397.95	1	$1,007	$2,038	($1,031)	49%	51%
26145	Synovectomy, tendon sheath, radical (tenosynovectomy), flexor tendon, palm and/or finger, each tendon	$682.56	$1,223.75	1	$580	$1,040	($460)	56%	44%
26715	Open treatment of metacarpophalangeal dislocation, single, includes internal fixation, when performed	$1,184.43	$2,397.95	1	$1,007	$2,038	($1,031)	49%	51%

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QUINCY MEDICAL GROUP
QUINCY MEDICAL GROUP ASC ELIGIBLE MEDICARE VOLUME

MEDICARE CODES - ASC SAVINGS OPPORTUNITY - BASED ON 2017 EXPERIENCE DATA

CPT	2018 Full Description	2018 Medicare Area-Adj. ASC Rate	2018 Medicare Area-Adj HOPD OPPS Rate	2017 Estimated ASC Eligible Medicare Cases [1,2]	Total Projected Cost in ASC	Total Projected Cost in HOPD	Projected ASC Annual Savings based on 2018 ASC vs HOPD rates	ASC Rates as Percent of HOPD	Percent Savings in ASC
26725	Closed treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; with manipulation, with or without skin or skeletal traction, each	$103.60	$194.81	1	$88	$166	($78)	53%	47%
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft	n/a	$0.00	1	$0	$0	$0	n/a	n/a
27266	Closed treatment of post hip arthroplasty dislocation; requiring regional or general anesthesia	$682.56	$1,223.75	1	$580	$1,040	($460)	56%	44%
27327	Excision, tumor, soft tissue of thigh or knee area, subcutaneous; less than 3 cm	$502.38	$1,222.02	1	$427	$1,039	($612)	41%	59%
27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)	n/a	$9,176.63	1	$0	$7,800	($7,800)	n/a	n/a
27610	Arthrotomy, ankle, including exploration, drainage, or removal of foreign body	$1,184.43	$2,397.95	1	$1,007	$2,038	($1,031)	49%	51%
27640	Partial excision (craterization, saucerization, or diaphysectomy), bone (eg, osteomyelitis); tibia	$1,184.43	$2,397.95	1	$1,007	$2,038	($1,031)	49%	51%
28092	Excision of lesion, tendon, tendon sheath, or capsule (including synovectomy) (eg, cyst or ganglion); toe(s), each	$682.56	$1,223.75	1	$580	$1,040	($460)	56%	44%
28112	Ostectomy, complete excision; other metatarsal head (second, third or fourth)	$1,184.43	$2,397.95	1	$1,007	$2,038	($1,031)	49%	51%
28113	Ostectomy, complete excision; fifth metatarsal head	$1,184.43	$2,397.95	1	$1,007	$2,038	($1,031)	49%	51%

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QUINCY MEDICAL GROUP
QUINCY MEDICAL GROUP ASC ELIGIBLE MEDICARE VOLUME

MEDICARE CODES - ASC SAVINGS OPPORTUNITY - BASED ON 2017 EXPERIENCE DATA

CPT	2018 Full Description	2018 Medicare Area-Adj. ASC Rate	2018 Medicare Area-Adj HOPD OPPS Rate	2017 Estimated ASC Eligible Medicare Cases [1,2]	Total Projected Cost in ASC	Total Projected Cost in HOPD	Projected ASC Annual Savings based on 2018 ASC vs HOPD rates	ASC Rates as Percent of HOPD	Percent Savings in ASC
28124	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); phalanx of toe	$280.51	$1,223.75	1	$238	$1,040	($802)	23%	77%
28208	Repair, tendon, extensor, foot; primary or secondary, each tendon	$1,184.43	$2,397.95	1	$1,007	$2,038	($1,031)	49%	51%
28289	Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; without implant	$1,184.43	$2,397.95	1	$1,007	$2,038	($1,031)	49%	51%
28298	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with proximal phalanx osteotomy, any method	$2,518.36	$5,082.33	1	$2,141	$4,320	($2,179)	50%	50%
28308	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; other than first metatarsal, each	$1,184.43	$2,397.95	1	$1,007	$2,038	($1,031)	49%	51%
28313	Reconstruction, angular deformity of toe, soft tissue procedures only (eg, overlapping second toe, fifth toe, curly toes)	$1,184.43	$2,397.95	1	$1,007	$2,038	($1,031)	49%	51%
28485	Open treatment of metatarsal fracture, includes internal fixation, when performed, each	$2,518.36	$5,082.33	1	$2,141	$4,320	($2,179)	50%	50%
28730	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse;	$6,863.09	$9,176.63	1	$5,834	$7,800	($1,967)	75%	25%
28750	Arthrodesis, great toe; metatarsophalangeal joint	$3,528.41	$5,082.33	1	$2,999	$4,320	($1,321)	69%	31%
28755	Arthrodesis, great toe; interphalangeal joint	$2,518.36	$5,082.33	1	$2,141	$4,320	($2,179)	50%	50%
28825	Amputation, toe; interphalangeal joint	$682.56	$1,223.75	1	$580	$1,040	($460)	56%	44%

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QUINCY MEDICAL GROUP
QUINCY MEDICAL GROUP ASC ELIGIBLE MEDICARE VOLUME

MEDICARE CODES - ASC SAVINGS OPPORTUNITY - BASED ON 2017 EXPERIENCE DATA

CPT	2018 Full Description	2018 Medicare Area-Adj. ASC Rate	2018 Medicare Area-Adj HOPD OPPS Rate	2017 Estimated ASC Eligible Medicare Cases [1,2]	Total Projected Cost in ASC	Total Projected Cost in HOPD	Projected ASC Annual Savings based on 2018 ASC vs HOPD rates	ASC Rates as Percent of HOPD	Percent Savings in ASC
29877	Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty)	$1,184.43	$2,397.95	1	$1,007	$2,038	($1,031)	49%	51%
30115	Excision, nasal polyp(s), extensive	$881.15	$1,993.49	1	$749	$1,694	($945)	44%	56%
30117	Excision or destruction (eg, laser), intranasal lesion; internal approach	$881.15	$1,993.49	1	$749	$1,694	($945)	44%	56%
30420	Rhinoplasty, primary; including major septal repair	$1,982.65	$3,933.20	1	$1,685	$3,343	($1,658)	50%	50%
30903	Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method	$50.64	$95.22	1	$43	$81	($38)	53%	47%
31254	Nasal/sinus endoscopy, surgical with ethmoidectomy; partial (anterior)	$1,636.13	$4,409.47	1	$1,391	$3,748	($2,357)	37%	63%
31267	Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus	$1,636.13	$4,409.47	1	$1,391	$3,748	($2,357)	37%	63%
33208	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular	$7,412.68	$8,836.75	1	$6,301	$7,511	($1,210)	84%	16%
33264	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; multiple lead system	$25,347.97	$28,067.79	1	$21,546	$23,858	($2,312)	90%	10%
35045	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, radial or ulnar artery	n/a	$3,866.27	1	$0	$3,286	($3,286)	n/a	n/a
35656	Bypass graft, with other than vein; femoral-popliteal	n/a	$0.00	1	$0	$0	$0	n/a	n/a
36005	Injection procedure for extremity venography (including introduction of needle or intracatheter)	$0.00	$0.00	1	$0	$0	$0	n/a	n/a

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QUINCY MEDICAL GROUP
QUINCY MEDICAL GROUP ASC ELIGIBLE MEDICARE VOLUME

MEDICARE CODES - ASC SAVINGS OPPORTUNITY - BASED ON 2017 EXPERIENCE DATA

CPT	2018 Full Description	2018 Medicare Area-Adj. ASC Rate	2018 Medicare Area-Adj HOPD OPPS Rate	2017 Estimated ASC Eligible Medicare Cases [1,2]	Total Projected Cost in ASC	Total Projected Cost in HOPD	Projected ASC Annual Savings based on 2018 ASC vs HOPD rates	ASC Rates as Percent of HOPD	Percent Savings in ASC
36011	Selective catheter placement, venous system; first order branch (eg, renal vein, jugular vein)	$0.00	$0.00	1	$0	$0	$0	n/a	n/a
36012	Selective catheter placement, venous system; second order, or more selective, branch (eg, left adrenal vein, petrosal sinus)	$0.00	$0.00	1	$0	$0	$0	n/a	n/a
36221	Non-selective catheter placement, thoracic aorta, with angiography of the extracranial carotid, vertebral, and/or intracranial vessels, unilateral or bilateral, and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed	$0.00	$2,259.72	1	$0	$1,921	($1,921)	n/a	n/a
36246	Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family	$0.00	$0.00	1	$0	$0	$0	n/a	n/a
36251	Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral	$0.00	$2,259.72	1	$0	$1,921	($1,921)	n/a	n/a
36589	Removal of tunneled central venous catheter, without subcutaneous port or pump	$295.30	$555.31	1	$251	$472	($221)	53%	47%

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QUINCY MEDICAL GROUP
QUINCY MEDICAL GROUP ASC ELIGIBLE MEDICARE VOLUME

MEDICARE CODES - ASC SAVINGS OPPORTUNITY - BASED ON 2017 EXPERIENCE DATA

CPT	2018 Full Description	2018 Medicare Area-Adj. ASC Rate	2018 Medicare Area-Adj HOPD OPPS Rate	2017 Estimated ASC Eligible Medicare Cases [1,2]	Total Projected Cost in ASC	Total Projected Cost in HOPD	Projected ASC Annual Savings based on 2018 ASC vs HOPD rates	ASC Rates as Percent of HOPD	Percent Savings in ASC
37191	Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed	n/a	$3,866.27	1	$0	$3,286	($3,286)	n/a	n/a
37220	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty	$2,336.20	$4,609.65	1	$1,986	$3,918	($1,932)	51%	49%
37224	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty	$2,336.20	$4,609.65	1	$1,986	$3,918	($1,932)	51%	49%
37227	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	$10,054.09	$14,522.80	1	$8,546	$12,344	($3,798)	69%	31%
37242	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms)	$4,145.84	$9,527.94	1	$3,524	$8,099	($4,575)	44%	56%
37765	Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions	$311.16	$2,259.72	1	$264	$1,921	($1,656)	14%	86%

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QUINCY MEDICAL GROUP
QUINCY MEDICAL GROUP ASC ELIGIBLE MEDICARE VOLUME

MEDICARE CODES - ASC SAVINGS OPPORTUNITY - BASED ON 2017 EXPERIENCE DATA

CPT	2018 Full Description	2018 Medicare Area-Adj. ASC Rate	2018 Medicare Area-Adj HOPD OPPS Rate	2017 Estimated ASC Eligible Medicare Cases [1,2]	Total Projected Cost in ASC	Total Projected Cost in HOPD	Projected ASC Annual Savings based on 2018 ASC vs HOPD rates	ASC Rates as Percent of HOPD	Percent Savings in ASC
41100	Biopsy of tongue; anterior two-thirds	$106.61	$416.88	1	$91	$354	($264)	26%	74%
41113	Excision of lesion of tongue with closure; posterior one-third	$881.15	$1,993.49	1	$749	$1,694	($945)	44%	56%
43226	Esophagoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) over guide wire	$580.62	$1,293.96	1	$494	$1,100	($606)	45%	55%
43274	Endoscopic retrograde cholangiopancreatography (ERCP); with placement of endoscopic stent into biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent	$1,710.67	$3,892.25	1	$1,454	$3,308	($1,854)	44%	56%
43882	Revision or removal of gastric neurostimulator electrodes, antrum, open	n/a	$0.00	1	$0	$0	$0	n/a	n/a
44361	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with biopsy, single or multiple	$580.62	$1,293.96	1	$494	$1,100	($606)	45%	55%
44378	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)	$580.62	$1,293.96	1	$494	$1,100	($606)	45%	55%
44950	Appendectomy;	n/a	$2,639.02	1	$0	$2,243	($2,243)	n/a	n/a
45334	Sigmoidoscopy, flexible; with control of bleeding, any method	$451.39	$848.86	1	$384	$722	($338)	53%	47%
45386	Colonoscopy, flexible; with transendoscopic balloon dilation	$451.39	$848.86	1	$384	$722	($338)	53%	47%
46080	Sphincterotomy, anal, division of sphincter (separate procedure)	$1,054.08	$2,099.16	1	$896	$1,784	($888)	50%	50%

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QUINCY MEDICAL GROUP
QUINCY MEDICAL GROUP ASC ELIGIBLE MEDICARE VOLUME

MEDICARE CODES - ASC SAVINGS OPPORTUNITY - BASED ON 2017 EXPERIENCE DATA

CPT	2018 Full Description	2018 Medicare Area-Adj. ASC Rate	2018 Medicare Area-Adj HOPD OPPS Rate	2017 Estimated ASC Eligible Medicare Cases [1,2]	Total Projected Cost in ASC	Total Projected Cost in HOPD	Projected ASC Annual Savings based on 2018 ASC vs HOPD rates	ASC Rates as Percent of HOPD	Percent Savings in ASC
46221	Hemorrhoidectomy, internal, by rubber band ligation(s)	$166.57	$643.61	1	$142	$547	($405)	26%	74%
46260	Hemorrhoidectomy, internal and external, 2 or more columns/groups;	$1,054.08	$2,099.16	1	$896	$1,784	($888)	50%	50%
46280	Surgical treatment of anal fistula (fistulectomy/fistulotomy); transsphincteric, suprasphincteric, extrasphincteric or multiple, including placement of seton, when performed	$1,054.08	$2,099.16	1	$896	$1,784	($888)	50%	50%
49082	Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance	$358.41	$673.99	1	$305	$573	($268)	53%	47%
49320	Laparoscopy, abdomen, peritoneum, and omentum, diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	$1,940.66	$4,069.08	1	$1,650	$3,459	($1,809)	48%	52%
49520	Repair recurrent inguinal hernia, any age; reducible	$1,233.18	$2,639.02	1	$1,048	$2,243	($1,195)	47%	53%
49587	Repair umbilical hernia, age 5 years or older; incarcerated or strangulated	$1,233.18	$2,639.02	1	$1,048	$2,243	($1,195)	47%	53%
49655	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated	$3,117.03	$6,885.40	1	$2,649	$5,853	($3,203)	45%	55%
51710	Change of cystostomy tube; complicated	$272.65	$512.73	1	$232	$436	($204)	53%	47%
52300	Cystourethroscopy; with resection or fulguration of orthotopic ureterocele(s), unilateral or bilateral	$1,115.88	$2,444.67	1	$949	$2,078	($1,129)	46%	54%

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CPT	2018 Full Description	2018 Medicare Area-Adj. ASC Rate	2018 Medicare Area-Adj HOPD OPPS Rate	2017 Estimated ASC Eligible Medicare Cases [1,2]	Total Projected Cost in ASC	Total Projected Cost in HOPD	Projected ASC Annual Savings based on 2018 ASC vs HOPD rates	ASC Rates as Percent of HOPD	Percent Savings in ASC
52647	Laser coagulation of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included if performed)	$1,625.91	$3,359.59	1	$1,382	$2,856	($1,474)	48%	52%
54235	Injection of corpora cavernosa with pharmacologic agent(s) (eg, papaverine, phentolamine)	$43.64	$208.07	1	$37	$177	($140)	21%	79%
54840	Excision of spermatocele, with or without epididymectomy	$721.43	$1,537.17	1	$613	$1,307	($693)	47%	53%
55250	Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s)	$721.43	$1,537.17	1	$613	$1,307	($693)	47%	53%
56810	Perineoplasty, repair of perineum, nonobstetrical (separate procedure)	$1,038.27	$2,060.31	1	$883	$1,751	($869)	50%	50%
57240	Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele, including cystourethroscopy, when performed	$1,702.00	$3,727.44	1	$1,447	$3,168	($1,722)	46%	54%
57268	Repair of enterocele, vaginal approach (separate procedure)	$1,038.27	$2,060.31	1	$883	$1,751	($869)	50%	50%
57282	Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus)	n/a	$5,699.62	1	$0	$4,845	($4,845)	n/a	n/a
57522	Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; loop electrode excision	$1,038.27	$2,060.31	1	$883	$1,751	($869)	50%	50%
58120	Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)	$1,038.27	$2,060.31	1	$883	$1,751	($869)	50%	50%
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	$3,117.03	$6,885.40	1	$2,649	$5,853	($3,203)	45%	55%

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MEDICARE CODES - ASC SAVINGS OPPORTUNITY - BASED ON 2017 EXPERIENCE DATA

CPT	2018 Full Description	2018 Medicare Area-Adj. ASC Rate	2018 Medicare Area-Adj HOPD OPPS Rate	2017 Estimated ASC Eligible Medicare Cases [1,2]	Total Projected Cost in ASC	Total Projected Cost in HOPD	Projected ASC Annual Savings based on 2018 ASC vs HOPD rates	ASC Rates as Percent of HOPD	Percent Savings in ASC
58563	Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)	$1,702.00	$3,727.44	1	$1,447	$3,168	($1,722)	46%	54%
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;	$3,117.03	$6,885.40	1	$2,649	$5,853	($3,203)	45%	55%
60240	Thyroidectomy, total or complete	$1,940.66	$4,069.08	1	$1,650	$3,459	($1,809)	48%	52%
60500	Parathyroidectomy or exploration of parathyroid(s);	$1,982.65	$3,933.20	1	$1,685	$3,343	($1,658)	50%	50%
61885	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array	$15,195.09	$16,651.77	1	$12,916	$14,154	($1,238)	91%	9%
63045	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; cervical	$2,518.36	$5,082.33	1	$2,141	$4,320	($2,179)	50%	50%
63046	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; thoracic	$2,518.36	$5,082.33	1	$2,141	$4,320	($2,179)	50%	50%
63286	Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, thoracic	n/a	$0.00	1	$0	$0	$0	n/a	n/a
63650	Percutaneous implantation of neurostimulator electrode array, epidural	$4,251.89	$5,489.53	1	$3,614	$4,666	($1,052)	77%	23%

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QUINCY MEDICAL GROUP
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MEDICARE CODES - ASC SAVINGS OPPORTUNITY - BASED ON 2017 EXPERIENCE DATA

CPT	2018 Full Description	2018 Medicare Area-Adj. ASC Rate	2018 Medicare Area-Adj HOPD OPPS Rate	2017 Estimated ASC Eligible Medicare Cases [1,2]	Total Projected Cost in ASC	Total Projected Cost in HOPD	Projected ASC Annual Savings based on 2018 ASC vs HOPD rates	ASC Rates as Percent of HOPD	Percent Savings in ASC
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling	$21,185.15	$25,284.47	1	$18,007	$21,492	($3,484)	84%	16%
64568	Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	$21,546.67	$25,284.47	1	$18,315	$21,492	($3,177)	85%	15%
64590	Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling	$15,234.11	$16,651.77	1	$12,949	$14,154	($1,205)	91%	9%
65426	Excision or transposition of pterygium; with graft	$748.16	$1,642.03	1	$636	$1,396	($760)	46%	54%
65930	Removal of blood clot, anterior segment of eye	$917.95	$1,741.51	1	$780	$1,480	($700)	53%	47%
66250	Revision or repair of operative wound of anterior segment, any type, early or late, major or minor procedure	$748.16	$1,642.03	1	$636	$1,396	($760)	46%	54%
66680	Repair of iris, ciliary body (as for iridodialysis)	$917.95	$1,741.51	1	$780	$1,480	($700)	53%	47%
66986	Exchange of intraocular lens	$917.95	$1,741.51	1	$780	$1,480	($700)	53%	47%
67935	Suture of recent wound, eyelid, involving lid margin, tarsus, and/or palpebral conjunctiva direct closure; full thickness	$748.16	$1,642.03	1	$636	$1,396	($760)	46%	54%
67961	Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; up to one-fourth of lid margin	$748.16	$1,642.03	1	$636	$1,396	($760)	46%	54%
68110	Excision of lesion, conjunctiva; up to 1 cm	$149.91	$1,642.03	1	$127	$1,396	($1,268)	9%	91%

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QUINCY MEDICAL GROUP ASC ELIGIBLE MEDICARE VOLUME

MEDICARE CODES - ASC SAVINGS OPPORTUNITY - BASED ON 2017 EXPERIENCE DATA

CPT	2018 Full Description	2018 Medicare Area-Adj. ASC Rate	2018 Medicare Area-Adj HOPD OPPS Rate	2017 Estimated ASC Eligible Medicare Cases [1,2]	Total Projected Cost in ASC	Total Projected Cost in HOPD	Projected ASC Annual Savings based on 2018 ASC vs HOPD rates	ASC Rates as Percent of HOPD	Percent Savings in ASC
68705	Correction of everted punctum, cautery	$129.03	$242.64	1	$110	$206	($97)	53%	47%
			Total	4,689	$4,488,636	$8,453,969	($3,965,333)	53%	47%

Notes and Assumptions:

[1] The primary CPT code was derived based upon the highest charge amount in an patient account; multiple procedures in a given case are not factored into the savings. The savings is based upon one code in a case which is conservative. CPT codes not on the CMS-approved Medicare ASC list are designated as "n/a"

[2] Medicare includes Medicare Advantage and Medicare volume.

POLSINELLI

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October 24, 2018

Tracey L. Klein
(312) 873-3613
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VIA FEDERAL EXPRESS – OVERNIGHT DELIVERY

Courtney R. Avery
Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Application for Permit - Quincy Medical Group Surgery Center
Request for Expedited Review

Dear Ms. Avery:

On behalf of Quincy Medical Group, please find enclosed an original and 1 copy of an Application for Permit to establish a multi-specialty ambulatory surgical treatment center and cardiac catheterization service in Quincy, Illinois, and a check in the amount of $2,500 for the application processing fee.

We respectfully request expedited review of the application and consideration of the project at the March 2019 Board meeting.

Thank you for your time and consideration of this application and the request for expedited review. If you have any questions or require any additional information to complete your review, please feel free to contact me.

Sincerely,

Tracey L. Klein

Enclosures – Original and 1 Copy of Application for Permit, Check for Processing Fee

cc: Carol Brockmiller, Chief Executive Officer, Quincy Medical Group
Ralph Weber, Weber Alliance, CON Consultant